ANNUAL REPORT
ON
OMBUDSMAN ACTIVITIES & SERVICES
Fiscal Year 2006

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

The role of the Health Benefits Ombudsman was established February 1, 2000, in accordance with §2.2-2818 of the Code of Virginia. 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 Ombudsman's staff consists of two Senior Health Benefits Specialists, two Health Benefits Specialists, a Retiree Specialist and a Medical Appeals Examiner who is a licensed registered nurse.

The primary objective of the Ombudsman and his Employee Services staff is to assist covered employees in understanding their rights and the processes available to them according to their state health plan. The Ombudsman ensures that covered employees receive timely responses to their inquiries from him or his Employee Services staff. In addition, the Ombudsman and Employee Services staff assists covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures.

The Ombudsman and his staff serve approximately 92,000 State employees and 23,000 local government employees in the The Local Choice Program who are covered by the State and Local Health Benefits Programs. Also, the Ombudsman and Employee Services staff is the resource for over two hundred and fifty human resource Benefits Administrators statewide who administer health benefits within State agencies and seek assistance with Program administration and policy application from the Ombudsman.

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

ACTIVITY DURING FISCAL YEAR 2006

The Ombudsman, during fiscal year 2006, recorded 5,293 formal case-specific inquiries from employees, agency Benefits Administrators, health care contractors, legislators,

providers and other interested parties. Inquiries for general information were not formally recorded. Inquiries take the form of correspondence, e-mails, telephone calls, and in-person consultations.

The majority of formal contacts with the Ombudsman and the Employee Services staff in FY 2006 pertained to eligibility and coverage for medical or surgical services under the COVA Care plan.

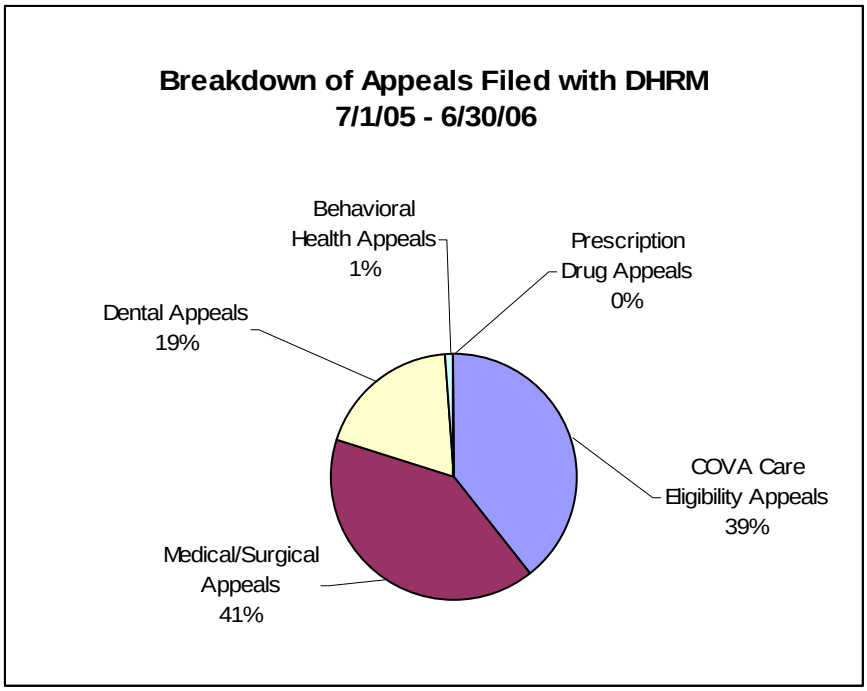
During FY 2006, the formal contacts with the Ombudsman and the Employee Services staff included 1,670 inquiries involving the new Medicare Part D plan for retiree medications, known as YOURx Plan. This plan became available January 1, 2006, to Medicare-eligible group members participating in the State Retiree Health Benefits Program. This is a Medicare-approved prescription drug plan offered by Medco. The Ombudsman and his staff, as well as the entire Office of Health Benefits staff, has been committed to providing assistance to our retiree group during this transitional time by working closely with Medco on issues as they arise.

APPEALS OVERVIEW

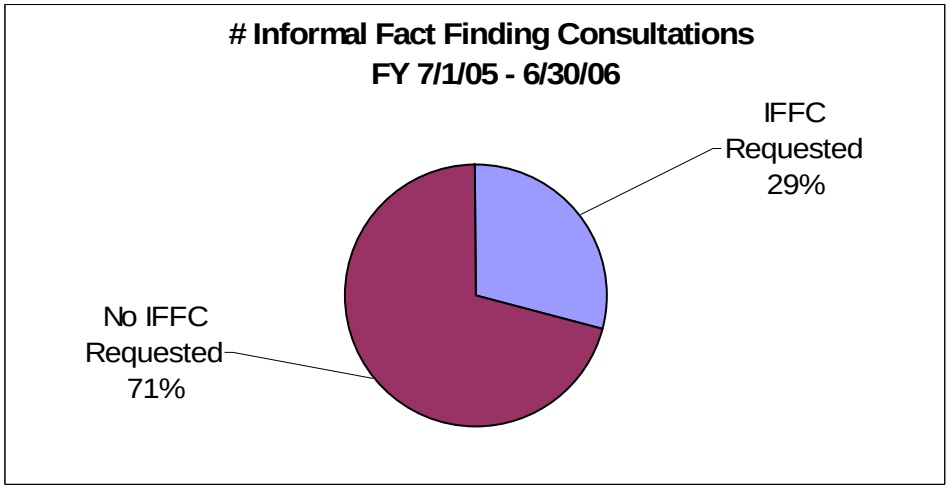
In all cases of appeal, every effort is made to assure that appellants receive the full extent of the benefits to which they are entitled under the rules of the Program. There is a strong emphasis on facilitating employee understanding of the Program and providing assistance to employees who encounter difficulties navigating the sometimes complex provisions and obligations related to employee health care. The Ombudsman is charged with oversight of the appeals process and he or a member of his Employee Services staff is the contact for appellants throughout the process. Working together, the Ombudsman and his staff strive to resolve appeals as early in the process as possible.

There are two kinds of appeals. Those that involve COVA Care plan eligibility pertain to whether or not an employee and/or dependent is qualified to receive coverage under the State Health Benefits Program. Appeals that are medical also include dental, prescription drug and behavioral health issues. When eligibility issues are unresolved at a lower level, the employee has the right to appeal to the Director of DHRM. Similarly, when an employee exhausts his/her medical, prescription drug, dental or mental health plan appeals, the employee has the right to appeal the denial of coverage to DHRM.

During FY 2006, there were eighty-nine (89) formal appeals to the Director of DHRM. Thirty-five (35) of these related to COVA Care eligibility and fifty-four (54) were medical. Additionally, with intervention by the Employee Services staff, twenty-three (23) appeals were resolved without going through the full appeal process. The total number of formal appeals to the Director of DHRM during FY 2006 represents a 5.9% increase in the total number of appeals (84) from the previous year.



When a health plan member appeals to the Director of DHRM, the opportunity for an informal fact finding consultation (IFFC) with the Director is offered each appellant. If the appellant chooses not to have an IFFC, the case will be decided based on the evidence submitted by the appellant and the health plan.



Twenty-six (26) IFFCs were conducted during this fiscal year. The Ombudsman and his staff conduct in-depth research on behalf of the appellant and the Director. A packet of information is then developed and given to both the appellant and the Director prior to the IFFC. This packet includes all information containing relevant contract or policy provisions, full case-related information, and a chronology of relevant actions and

communications. During the IFFC, the appellant is given the opportunity to describe the issue as he sees it, to state the relief he seeks and ask questions. The Director and Ombudsman then collaborate with the appellant concerning the issue and determine any additional information that may be useful in deciding the appeal. The Ombudsman and his Employee Services staff assist with the development of all additional information.

An independent review is not required for an appeal involving eligibility issues and some medically-related appeals such as medical, prescription drug, dental, behavioral health appeals that are resolved early in the process. After thorough review of the evidence, the Director decides these appeals, and communicates decisions to appellants by letter. The Director's appeal decision is final and binding. Once the Director has ruled on the case, if the 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 APA appeals of any type during this fiscal year.

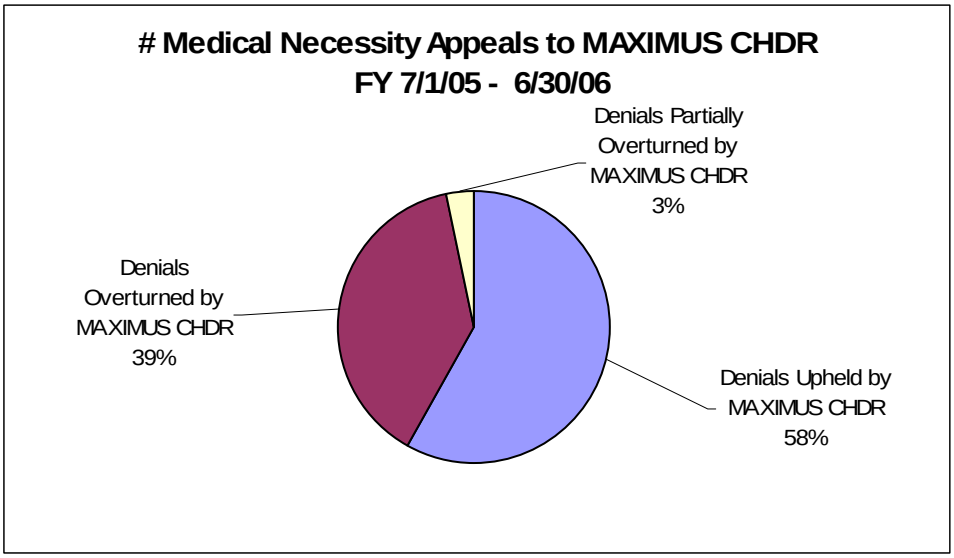
INDEPENDENT REVIEW APPEALS

For appeals pertaining to medical necessity, DHRM has a contract with MAXIMUS Center for Health Dispute Resolution (MAXIMUS CHDR) to conduct an independent, impartial third party review. Such reviews pertain only to the issue of medical necessity, which is defined as a service requested to treat an illness, injury or pregnancy related condition, which a provider has diagnosed or reasonably suspects. To be medically necessary, the service must: 1) be consistent with the diagnosis of the condition; 2) be in accordance with standards of generally accepted medical practice; 3) not be for the convenience of the patient, the patient's family, or the provider; 4) be the most suitable cost-effective supply (i.e., medications, durable medical equipment, etc.) or level of service which can be safely provided; and 5) be a covered benefit under the Commonwealth's Health Benefits Plans.

For appeals requiring independent review, the Ombudsman and his Employee Services staff assist with the development of all additional information and are responsible for developing a complete body of case-specific medical information for expert review by the independent third party clinical review entity, MAXIMUS Center For Health Dispute Resolution (MAXIMUS CHDR). Once all information is accumulated, including medical information provided by the plan, the entire package goes to MAXIMUS CHDR.

After MAXIMUS CHDR reviews the material, it renders a decision, which is binding on DHRM. After MAXIMUS CHDR sends its decision to DHRM, the Director of DHRM makes the final decision relating to the appeal and communicates that decision, in writing, to the appellant. The Director of DHRM advises the appellant that he may appeal under the provisions of the Administrative Process Act (APA), Rules of the Supreme Court, within 30 days of the final decision.

During FY 2006, thirty-one (31) appeals were sent to MAXIMUS CHDR for independent external clinical review, of which twelve (12) denials were overturned and one (1) denial was partially overturned.



CUSTOMER FEEDBACK

At the close of each fact-finding, whether medical or administrative, the appellant is asked to suggest any area where we may improve the appeals process, Program communications, or any other aspect of the Health Benefits Program. Feedback from employees who have experienced a problem is a very important tool for understanding how we may improve various aspects of the Program or communicate more effectively. The Program regularly acts on suggestions from employees to make appropriate improvements. The greater our understanding of employees' needs, the better we can serve those needs.

COMMUNICATIONS AND LIAISON WITH CONTRACTORS

The Ombudsman takes an active role in the development of communications for all State Health Benefits Program publications, web site information, and contractor communications to employees. The Ombudsman and his Employee Services staff constantly review communications from OHB and its various contractors (i.e., Anthem, Medco, Delta Dental, and ValueOptions). Furthermore, the Ombudsman and his Employee Services staff communicate frequently with contractors to discuss coverage, eligibility and claims issues.

EFFECTIVENESS OF OMBUDSMAN'S ROLE

The Ombudsman and his Employee Services staff continue to make every effort to assure that employees receive the full extent of the benefits to which they are entitled under their health benefits plan. Additionally, the Ombudsman and his staff fulfill their obligation of assisting employees in understanding their rights and in explaining the procedures for contesting adverse decisions rendered by the health plan.

CONCLUSION

The Ombudsman and his Employee Services staff provide assistance to covered state employees and members of the Local Choice Program in understanding and accessing their health plan benefits. In addition, employees are provided the necessary assistance in using all procedures and processes in place, including appeal procedures, in a fair and consistent manner. The Ombudsman and his Employee Services staff also assist Benefits Administrators statewide who seek assistance with the application and administration of health care policy. The Ombudsman and his Employee Services staff work to make sure all employees are treated fairly and consistently, to manage the expectations of employees and to educate employees and Benefits Administrators regarding employee health benefits.