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Correspondence Memorandum

Date: April 21, 2016

To: Group Insurance Board

From: Liz Doss-Anderson, Ombudsperson
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James Kates, Ombudsperson
Dan Hayes, Attorney/Supervisor

Subject: 2015 Ombudsperson Contact Report

This memo is for informational purposes only. No Board action is required.

This report contains information about complaints and inquiries received at the Department of Employee Trust Funds (ETF) by Ombudsperson Services staff. The complaints and inquiries came from members, their families, employers, and external advocacy organizations as they relate to Wisconsin Retirement System (WRS) benefits.

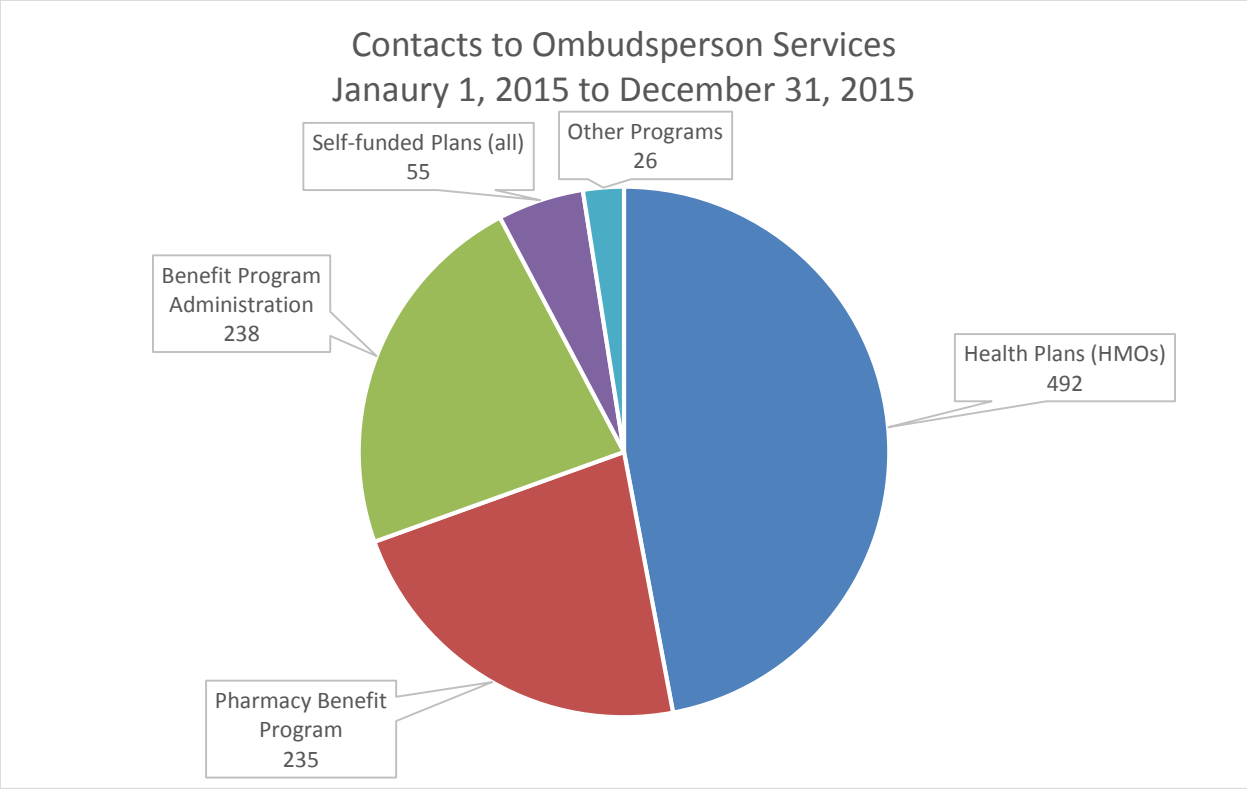
Complaint and Inquires Overview
In 2015, Ombudsperson Services received 1046 complaints and inquiries. This is very consistent with prior years, with the ombudsperson staff experiencing approximately 1000 contacts per year. The health insurance program generated the majority of contacts including 492 complaints and inquiries (a little less than half of total contacts) derived from health plan decisions or other plan actions. In addition, there were 238 contacts (23%) related to Benefit Program Administration issues. The Benefit Program Administration category relates to health insurance contacts regarding matters that do not involve action by a health plan. These contacts include member complaints or inquiries and educational contacts regarding plan design, enrollment and eligibility provisions, employer errors and systems issues. Please see the chart below for a breakdown of complaints and inquiries.

Reviewed and approved by David Nispel, General Counsel, Legal Services

David H. Nispel

Electronically Signed 5/10/16

Board	Mtg Date	Item #
GIB	5.18.16	6C



Please note that the "Other Programs" category includes: contacts regarding TASC FSA/Commuter Benefits Programs, ICI, optional dental plans, EPIC, LTC Insurance, Life Insurance, VSP Vision Plan, Deferred Compensation, Duty Disability, and the Sick Leave Conversion Credit program.

Types of Complaints and Inquiries

As shown above, the bulk of the contacts Ombudsperson Services receive involve the group health insurance program. These contacts range from elevated inquiries referred by ETF's call center to complex written complaints. In 2015, the five types of issues with the most complaints and inquiries included:

- General program provisions and design (298 contacts)
- Enrollment and eligibility (251 contacts)
- Billing and claims processing (107 contacts)
- Non-covered services (67 contacts)
- It's Your Choice/open enrollment issues (58 contacts)

There were two additional categories that received a relatively high number of contacts. Those were premium issues with 41 contacts and prior authorization issues with 39 contacts.

<u>General Program Provisions and Design</u>

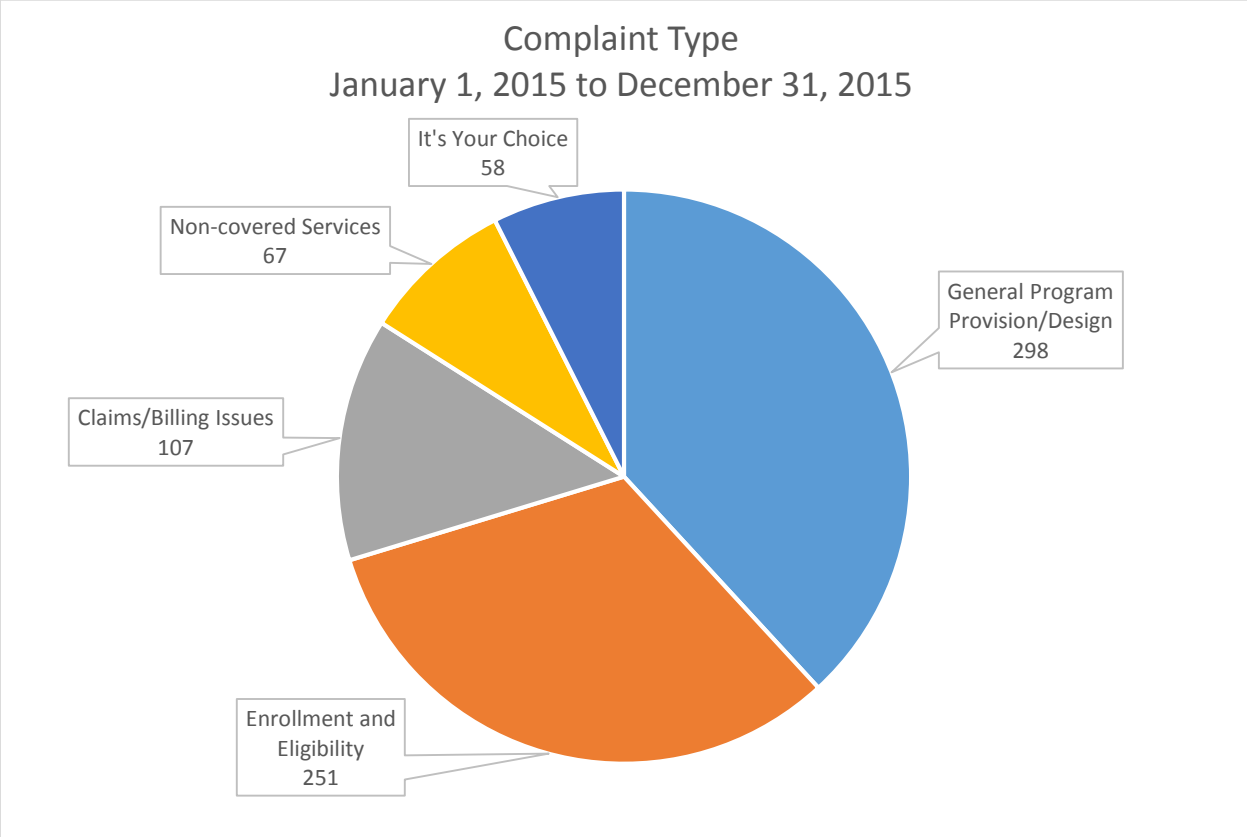
In 2014, there was a significant increase in complaints regarding general program provisions and design: 327 contacts compared to 110 in the prior year. This trend

continued in 2015 with 298 contacts in this category and another 58 contacts related to the It's Your Choice open enrollment period (many of which involve program provision and design questions specific to open enrollment). This category includes member concerns about changes to their benefits, education on changes like the high deductible health plan in conjunction with a health savings account, the move to uniform dental benefits and the questions about ETF process and procedures.

Enrollment and Eligibility

Enrollment and eligibility issues also continue to rise. In 2013, there were 123 contacts on issues in this category, in 2014 there were 185, and last year the number rose again to 251. Member issues included problems with the annual disabled dependent review process, difficulties with COBRA continuation contracts and missed enrollment opportunities.

These issues can be caused by problems with ETF system limitations, human error, employer error, or misinformation within the member's health plan. Enrollment issues can also occur with the Navitus Medicare RX Part D plan due to required Medicare Part D participation and federal rules administered by the Center for Medicare and Medicaid Services (CMS).



Trends
Based on benefit changes for 2015, Ombudsperson Services focused on helping members better understand the following topics:

- The High Deductible Health Plan (HDHP) and accompanying Health Savings Account (HSA) continued to generate questions from members seeking more information on how the plan worked.

- Members continued to face issues related to the Uniform Dental Benefits, including changes in what was covered in the past under their health plan, loss of providers and coordination of benefits with supplemental dental plans.

- When health plans have issues with their claims processing systems that result in improperly paid or denied claims, Ombudsperson Services often acts as facilitator to resolve the member's claims issue and also ensure that the health plan is addressing the problem with their system.

- Throughout the year, Ombudsperson Services received many contacts from members with questions about the Segal Reports to the GIB. During the annual It's Your Choice enrollment period there was a significant amount of concern from members about the cost-share changes for 2016, in particular the pharmacy benefit changes.

Because of the changing nature of benefits, especially in the health insurance program, Ombudsperson Services continues to have a strong focus on member outreach and education as well as continuing to resolve member complaints.

We believe the 2015 It's Your Choice open enrollment period went well considering the number of major changes that impacted members, the change in health plan names and placing more information on the web site. There were a few enrollment issues for some members who didn't understand the stand-alone dental option for 2016.

Looking Ahead
Plan and benefit design was significantly changed in 2016 as more member cost-sharing was added and a new standalone dental plan was put into place. Ombudsperson Services continues to educate and assist members with these changes and how best to utilize their medical, dental and pharmacy benefits.

The largest number of inquiries and complaints we received regarding the 2016 benefit changes involve the prescription drug benefit and the move from copayments to coinsurance for levels 2, 3 and 4. In particular, members have experienced difficulty with the Level 3 coinsurance, with many seeing their monthly out-of-pocket cost rise from $35 to $150 per drug. This has been particularly frustrating for some members

because this cost is not applied to the annual out-of-pocket limit. We expect these types of contacts to continue.

Ombudsperson Services staff regularly advises members about rights to independent review when a claim has been denied on the basis of medical judgment. Members are increasingly interested in this process as out-of-pocket costs rise. They also appreciate the same specialty review that an independent review offers and that the process reaches resolutions quickly.

In 2016, we may continue to experience a rise in enrollment and eligibility contacts as the general trend continues along with the state's implementation of the State Transforming Agency Resources Project (STAR). STAR is a large project that overhauls and consolidates the State's IT systems. Some wrinkles with processes such as file transferring have resulted in enrollment and eligibility issues for members.

We also expect to be called on to assist members with issues regarding the Flexible Spending Account, Health Savings Accounts and Commuter Benefits Programs, which are now administered by TASC, the new third party administrator. Members have experienced difficulty with logging onto the online portal and have questions about substantiation of claims.

Throughout the year, staff will work collaboratively with other business areas to develop education and outreach related to 2017 health and pharmacy benefit program changes, such as the move to a new wellness vendor, general information related to self-funded health plans, and any other changes that may be made.

Ombudsperson Services also continues to minimize the number of appeals to ETF-related boards and plays a major role in resolving member complaints by intervening and/or providing education shortly after a member's contact with ETF. Based on the very small number of formal appeals, our work demonstrates the value and efficiency of early intervention. The educational aspects and timeliness of early intervention also help Ombudsperson Services maintain and improve quality customer service and the administration of WRS benefit programs. In addition, we work with the Office of Strategic Health Policy, to identify areas of improvement with all our health plans and pharmacy benefit manager.

Staff will be available at the Board meeting to answer any questions.