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Correspondence Memorandum

Date: July 22, 2016

To: Group Insurance Board

From: Vickie Baker, Ombudsperson
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Dan Hayes, Attorney/Supervisor

Subject: Semi-Annual Ombudsperson Contact Report
January 1, 2016 through June 30, 2016

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

This report contains information about complaints and inquiries received by the Department of Employee Trust Funds (ETF) Ombudsperson Services staff. Complaints and inquiries are received from members, their families, employers, and external advocacy organizations and are related to benefits under the authority of the Group Insurance Board (Board).

From January 1 through June 30, 2016, Ombudsperson Services received 481 complaints and inquiries from members or their representatives, a small decrease in comparison with the first six months of 2015. During the same period, Ombudsperson Services received a substantially larger number of written complaints, which have the potential to become Board Appeals: 33 compared with 11 for the first half of 2015. Twelve of these written complaints related to Non-covered Services. Of these 12, six complaints were specific to Copay Reductions for Tier 3 drugs. There were also six written complaints related to services obtained out-of-network, which can to some extent be accounted for by changes in the service areas of some of the plans.

Regarding overall contacts, actions of health insurance plans generated the majority with 240 complaints and inquiries, approximately 50% of the total. This compares with 190 contacts in 2015. A chart showing the breakdown of these complaints and inquiries by health plan can be found on page 5 of this report.

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

David H. Nispel — Electronically Signed 8/9/16

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Members with ETF benefit program administration issues resulted in the second largest number of contacts with 144, or 38% of the total. The majority of these contacts related to the health insurance program, but involved general inquiries and issues that did not reflect any activity by the health plans. The health insurance and pharmacy benefit programs involve the most complex and time consuming issues for staff to resolve.

Most of the contacts were related to the following categories:

- General program provisions and design
- Enrollment and eligibility
- Increased Out-Of-Pocket (OOP) expenses for prescription drugs

Additional categories with noticeable complaint and inquiry numbers were:

- Non-covered or excluded benefits
- Plan service and administration

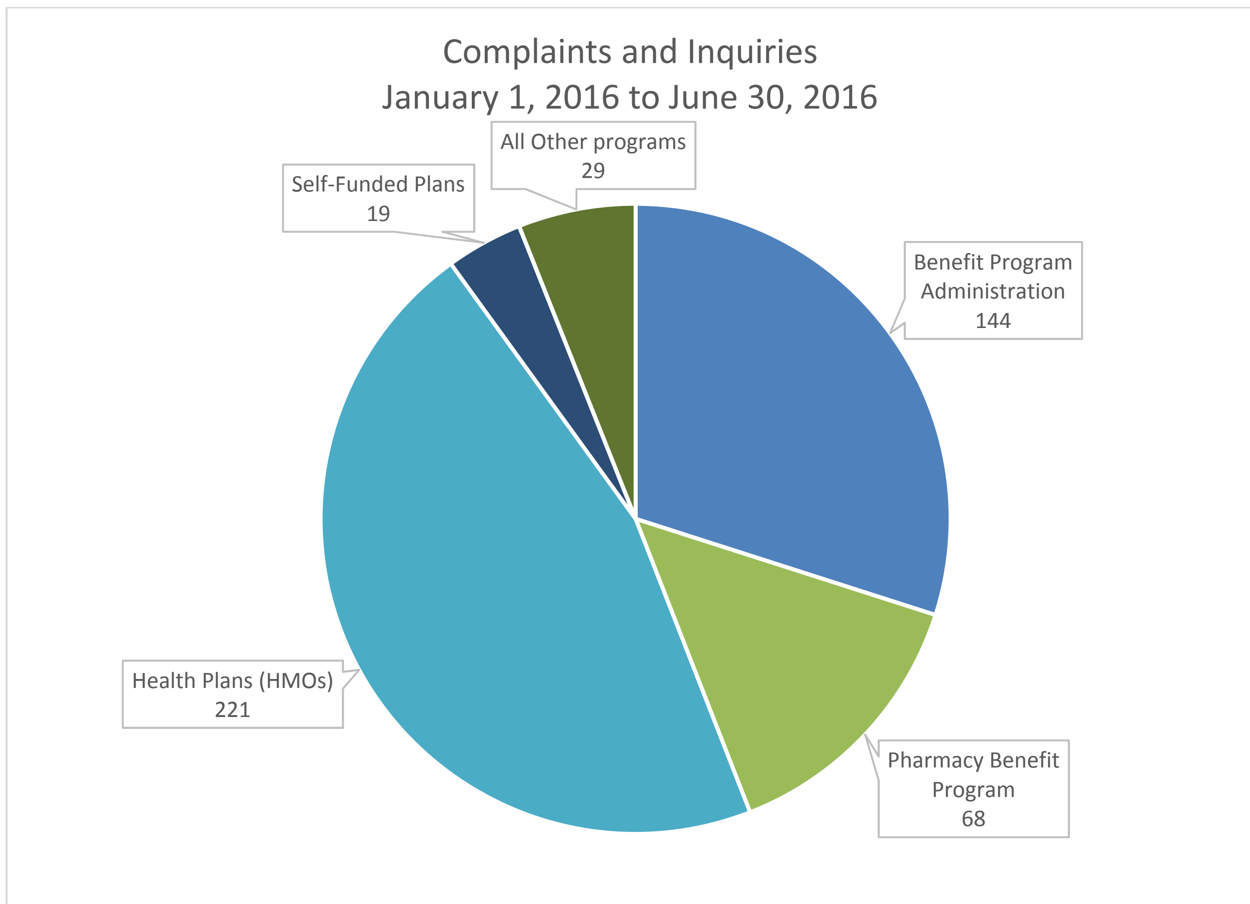
Ombudsperson Services staff continued to help members understand various aspects of their health insurance, including coordination of benefits, prior authorization requirements, and dental coverage.

Staff assisted members with 109 complaints and inquiries regarding General Program Provisions or Design. The second highest complaint and inquiry category was Enrollment and Eligibility with 100 contacts, a decrease compared to 143 in the first six months of 2015. This decrease was due in part to the spike in Enrollment and Eligibility issues created by the introduction of high-deductible health plans for 2015. Other contact categories are smaller: Billing and Claims Processing, 66 contacts; Non-covered or Excluded benefits, 43 contacts; Pharmacy Copay Reduction requests, 26 contacts.

The higher number of contacts related to General Program Provisions and Design, in large part, reflects the fundamental contract changes for 2016. The introduction of higher deductibles and the substantial increase in the OOP expenses for prescription drugs account for the majority of the contacts related to General Program Provisions and Design.

For example, there were significant increases to OOP expenses for our members in 2016. Most notably, these increases came in the form of higher deductibles, increased out-of-pocket limits, and substantially increased coinsurance for certain prescription drugs. Specifically, contacts related to Tier 3 drug coinsurance rising from $35 to $150 max per 30-day supply indicate that this increase is creating hardships for members. This is compounded by the fact that the coinsurance paid for Tier 3 drugs does not count towards members’ annual OOP maximum. Members have also expressed concerns that their inability to pay for prescription drugs will result in adverse health issues.

In the chart below, General Program Provision and Design contacts encompass a significant majority of the issues included in the Benefit Administration category. This category reflects issues raised by members that are not related to an action taken by their health plan. For example, if a member was upset because a specific benefit was not covered in the health plan's contract, the issue was attributed to benefit administration rather than to the health plan because all plans are required to follow contract provisions. This also applied to many contacts related to increase in OOP expenses for prescription drugs that can be attributed the general program provisions, versus the pharmacy benefits manager (PBM).



Please note that the "Other Programs" category includes: contacts regarding TASC ERA/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.

The number of contacts relating to action taken by the PBM reduced from 150 for the first half of 2015 to 68 during the same period in 2016. Note that much of the reduction in PBM contacts for 2016 is related to the fact that in 2015, Navitus contracted with a new Medicare D administrator, and that this resulted in many member enrollment issues for 2015 that were not encountered again in 2016.

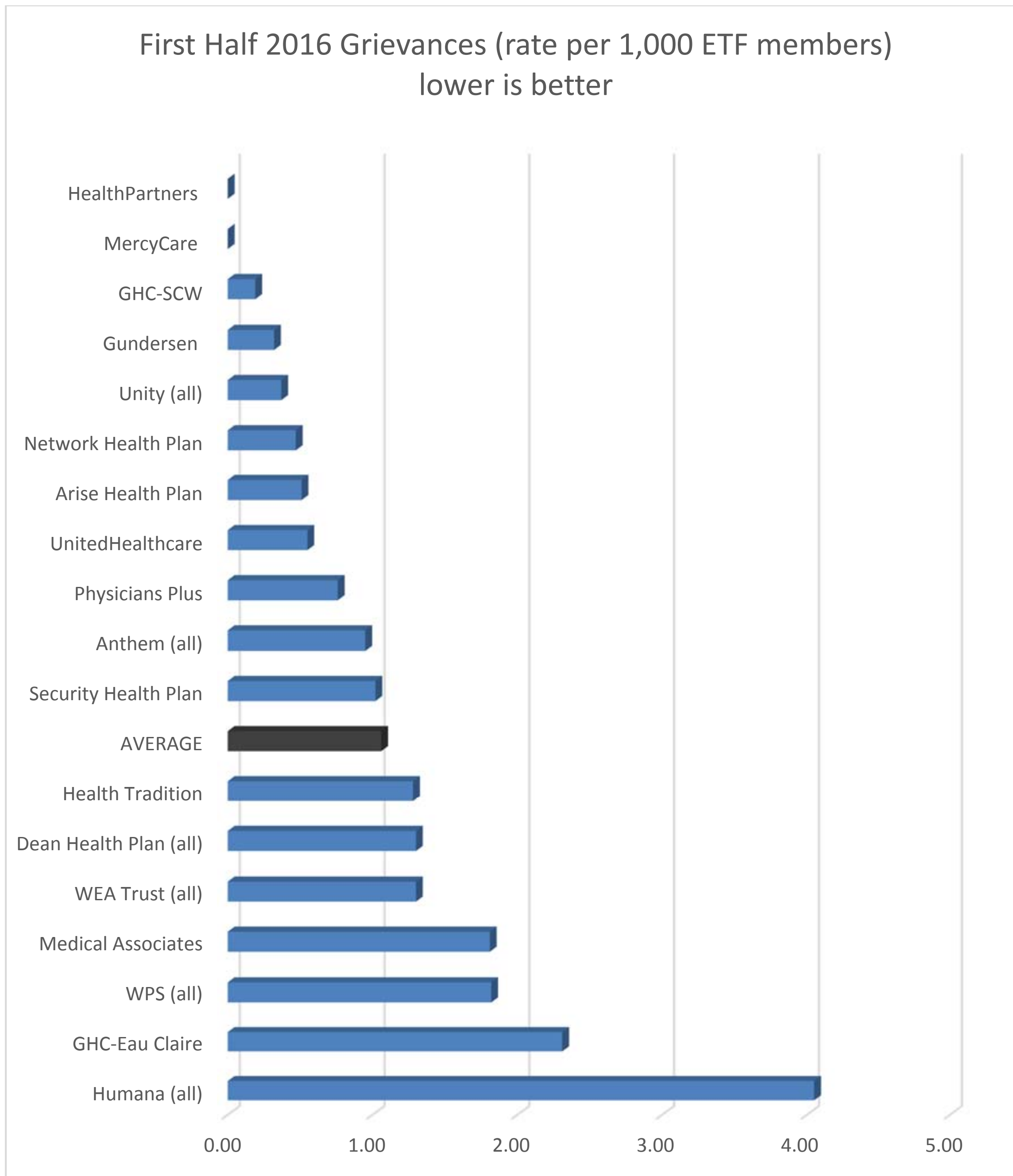
Of 240 contacts related to the health insurance plans, 100 were related to Enrollment and Eligibility issues. The majority of these can be attributed to issues related to the State Transforming Agency Resources (STAR) system used by State agencies and to a relatively large number of Medicare-eligible retirees who were mistakenly enrolled in an IYC (non-Medicare) health plan at the beginning of 2016.

Looking Ahead

During the second half of 2016, Ombudsperson Services staff will stay involved with preparations for the annual It's Your Choice (IYC) open enrollment activities, including review of the IYC member materials, participation in the IYC Employer Kickoff event, internal staff trainings, and employer health fairs across the state. Staff also continues to participate in the enhancements to ETF IT Infrastructure as part of Benefits Administration System-related projects.

As always, we continue to emphasize early intervention in the resolution of all matters. Our goal is to keep the number of Board appeals at a minimum. As a result, our resources can be better used to focus on quality assurance and enhancements to member education. This approach allows us to maintain high quality customer service and improve the administration of all WRS benefit programs.

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


First Half 2016 Grievances (rate per 1,000 ETF members)
lower is better
HealthPartners
MercyCare
GHC-SCW
Gundersen
Unity (all)
Network Health Plan
Arise Health Plan
UnitedHealthcare
Physicians Plus
Anthem (all)
Security Health Plan
AVERAGE
Health Tradition
Dean Health Plan (all)
WEA Trust (all)
Medical Associates
WPS (all)
GHC-Eau Claire
Humana (all)
0.00
1.00
2.00
3.00
4.00
5.00