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Correspondence Memorandum

Date: April 20, 2017

To: Group Insurance Board

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

Subject: Annual Ombudsperson Contact Report
January 1, 2016 through December 31, 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 December 31, 2016, Ombudsperson Services received 925 contacts involving complaints and inquiries from members or their representatives, a small decrease in comparison with 2015. During the same period, Ombudsperson Services received 45 written complaints that have the potential to become Board appeals. Of these 45 complaints, 13 were related to non-covered/excluded benefits, and 11 to general program provisions or design. The remainder consisted primarily of enrollment and eligibility issues, plan service or administration.

Actions of health insurance plans generated the majority of contacts, with 519 complaints and inquiries, approximately 56% of the total. This compares with 492 contacts in 2015. Members with ETF benefit program administration issues comprised the second largest number of contacts, with 228 (25% 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. Issues with the health insurance and pharmacy benefit programs are the most complex and time-consuming to resolve.

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

David A. Nispel Electronically Signed 5/8/17

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The majority of these contacts related to the following categories:

- General program provisions and design
- Incorrect enrollment of Medicare-eligible members
- Increased out-of-pocket (OOP) expenses for prescription drugs

Additional categories with noticeable complaint and inquiry numbers were:

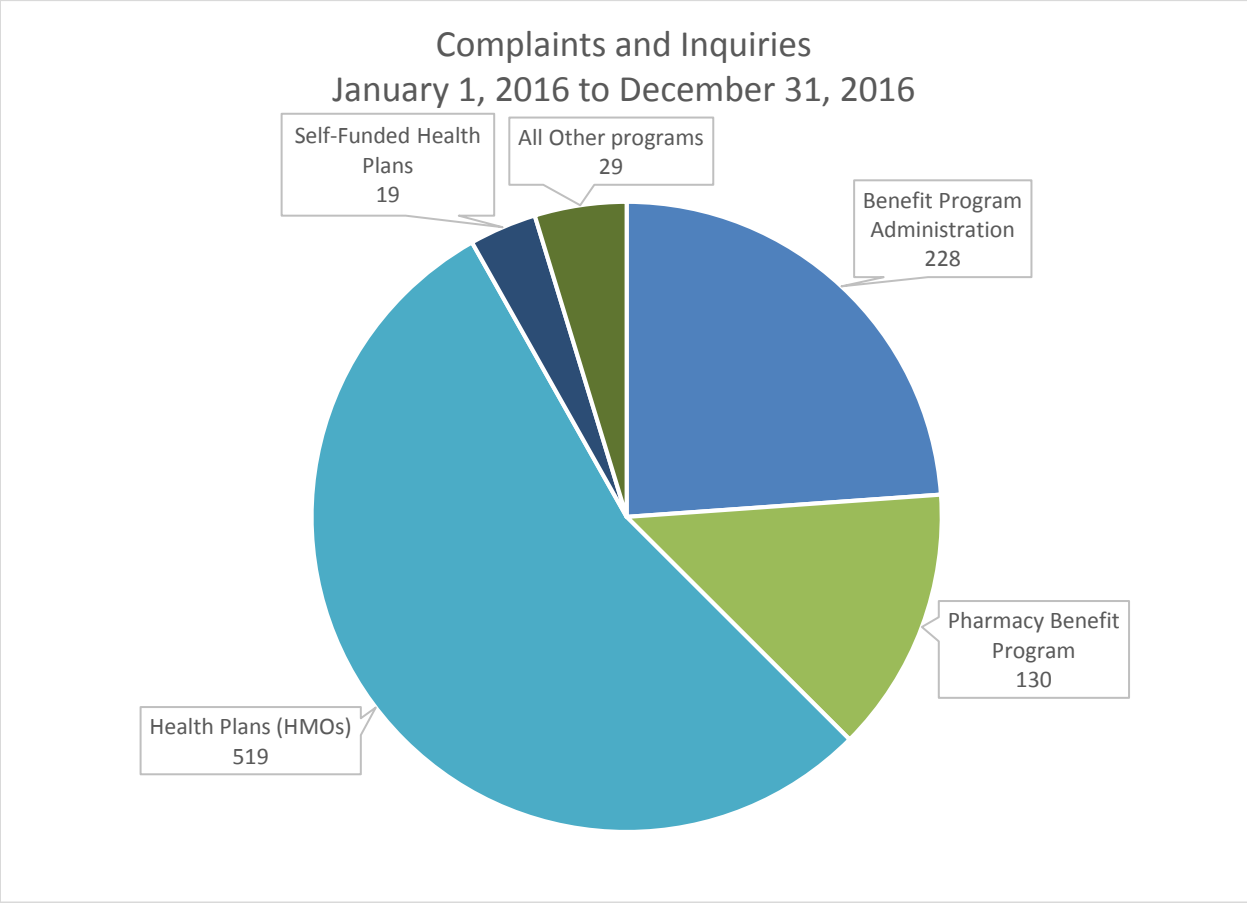
- Non-covered or excluded benefits
- Plan service and administration
- Inquiries regarding the transition to StayWell as the wellness administrator

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 209 complaints and inquiries regarding General Program Provisions or Design. The second-highest complaint and inquiry category was Enrollment and Eligibility, with 185 contacts. These ratios are consistent with contacts received by Ombudsperson Services in previous years. Other contact categories include: Billing and Claims Processing, 125 contacts; Non-covered or Excluded benefits, 75 contacts; and, Pharmacy Copay Reduction requests, 29 contacts. Note that we received fewer contacts regarding Pharmacy Coinsurance Reduction requests in the second half of 2016, as most members contacted us early in the year when the substantial OOP increases for pharmacy benefits were implemented.

The higher number of contacts related to General Program Provisions and Design, in large part, reflect the benefit changes for 2016. The substantial increase in the OOP expenses for prescription drugs and difficulties members encountered determining which benefits would be covered accounted for the majority of the contacts in this category.

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 the increase in OOP expenses for prescription drugs which are attributable to the general program provisions rather than the pharmacy benefits manager.



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.

Of 519 contacts related to the health insurance plans, 85 were Enrollment and Eligibility issues. ETF experienced a spike in Enrollment and Eligibility issues early in 2016 that can be associated with the STAR system conversion used by State agencies. This trend decreased somewhat in the second half of 2016. Incorrect enrollment of Medicare-eligible members created most of the other Enrollment and Eligibility contacts for 2016.

Looking Ahead

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-sponsored benefit fairs across the state. Staff will also continue to participate in the enhancements to ETF IT Infrastructure as part of Benefits Administration System-related projects. Additionally, the potential switch to self-insurance and/or a regional coverage model will likely create additional opportunities for Ombudsperson Services to educate and assist WRS members.

There were significant increases to OOP expenses for our members in 2016. Most notably, these increases came in the form of 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.

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 so that our resources can be better used to focus on quality assurance and member education enhancements. 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.