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Correspondence Memorandum

Date: August 3, 2017

To: Group Insurance Board

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

Subject: Semi-Annual Ombudsperson Contact Report
January 1, 2017 through June 30, 2017

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

This report contains information about complaints and inquiries handled 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).

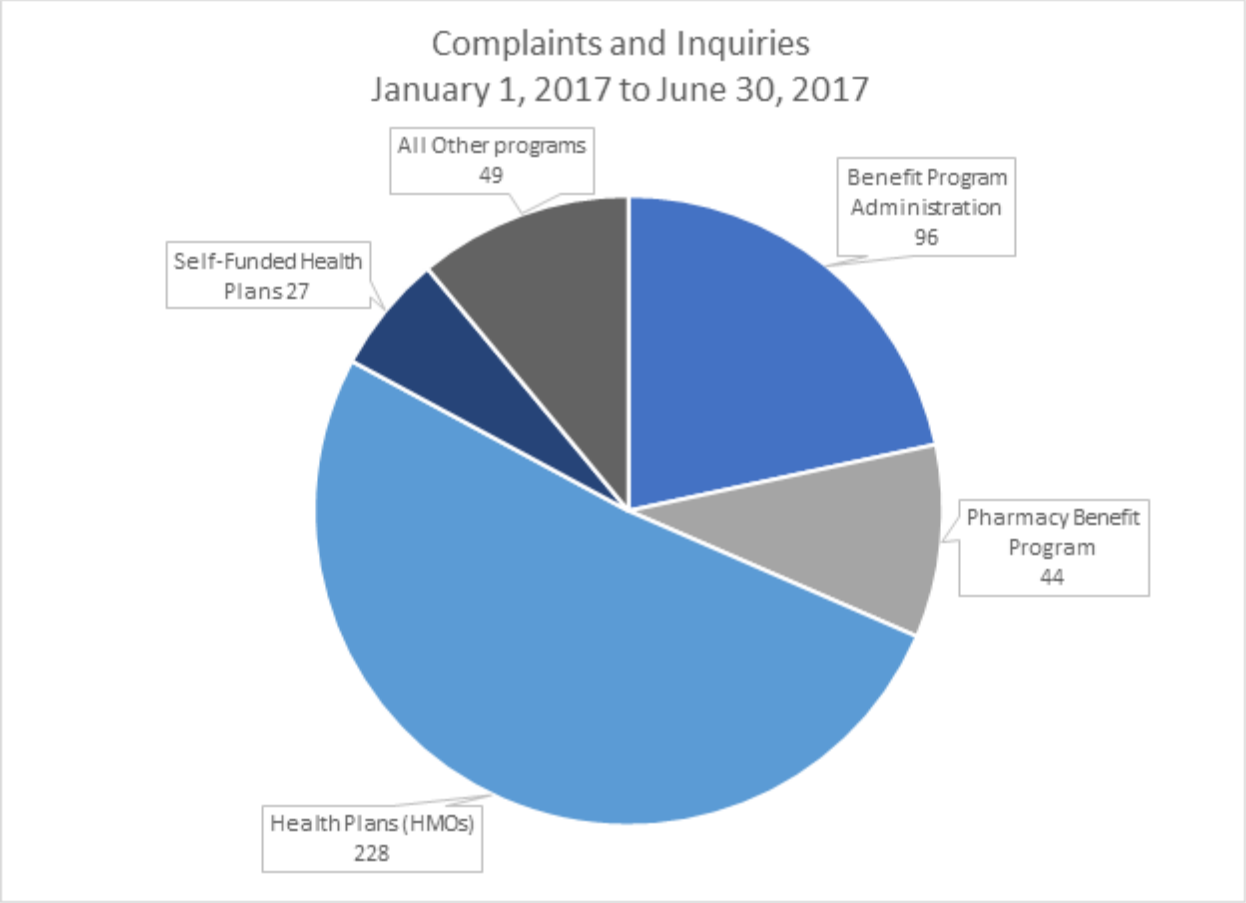
From January 1 through June 30, 2017, Ombudsperson Services received 444 complaints and inquiries from members or their representatives, a small decrease compared to the first six months of 2016. We also received 20 written complaints, which have greater potential to become Board appeals. Actions of health insurance plans generated most of the complaints and inquiries with 255, approximately 57% of the total received. This compares with 240 such contacts during the same period in 2016.

Members with ETF benefit program administration issues resulted in the second largest number of contacts with 96, or 22% of the total. Most of these contacts related to the health insurance program, but they 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.

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

David A. Nispel Electronically Signed 8/17/17

Board	Mtg Date	Item #
GIB	8.30.17	9E



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.

Most of the contacts received by Ombudsperson Services were related to the following categories:

- General program provisions and design
- Enrollment and eligibility

Additional categories with noticeable complaint and inquiry numbers were:

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

The numbers of complaints and inquiries in these top-four categories are similar to last year and are summarized below.

Complaint & Inquiries
January 1 – June 30, 2017

Contact Type	2016	2017
General Program Provisions and Design	109	101
Enrollment and Eligibility	100	100
Billing and Claims Processing	66	61
Non-covered or Excluded benefits	43	54

The large number of contacts related to General Program Provisions and Design continues to reflect the significant contract changes implemented for 2016. Changes such as the introduction of higher deductibles and the substantial increase in the out-of-pocket (OOP) expenses for prescription drugs account for most of the contacts related to General Program Provisions and Design, and Ombudsperson Services continues to receive these complaints.

General Program Provision and Design contacts still encompass most of the issues; these are included in the Benefit Program 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 that can be attributed to general program provisions, versus the pharmacy benefits manager (PBM).

Ombudsperson services no longer receives many contacts regarding Pharmacy Copay Reduction requests, as members are now going straight to the IRO process or Navitus when a copay reduction request is denied. Most of the contacts regarding prescription drug costs now fall under General Program Provision and Design.

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

Enrollment and eligibility issues caused 100 contacts. Forty-four were related to members being incorrectly enrolled or disenrolled in the VSP vison care plan at the beginning of the year. There also continue to be complaints when members or their dependents are enrolled incorrectly in the Humana Medicare Advantage plan when they reach Medicare eligibility.

Looking Ahead

During the second half of 2017, Ombudsperson Services staff will stay involved with preparations for the annual Its 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 continue to participate in the enhancements to ETF IT Infrastructure as part of Benefits Administration System-related projects.

Members report that the increases to OOP expenses implemented in 2016 continue to create hardships for our members. Most notably, several members have indicated they faced financial difficulties due to increased coinsurance for certain prescription drugs and increased out-of-pocket limits. This is compounded by the coinsurance paid for Tier 3 drugs not counting towards members' annual OOP maximum. Staff have also spoken with members who have expressed concerns that their inability to pay for prescription drugs will result in adverse health issues. Additionally, Ombudsperson services is now receiving complaints when prescription drugs are moved to a higher tier or removed from the Navitus formulary altogether. Ombudsperson Services will continue to help members understand the prescription drug benefit structure and the value that their health insurance provides.

As always, we continue to emphasize early intervention in the resolution of all matters. Our goal is to keep the number of Departmental Determinations and Board appeals at a minimum. As a result, the department's 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.