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Correspondence Memorandum

Date: April 17, 2018

To: Group Insurance Board

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

Subject: 2018 Annual Ombudsperson Contact Report
January 1 through December 31, 2017

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

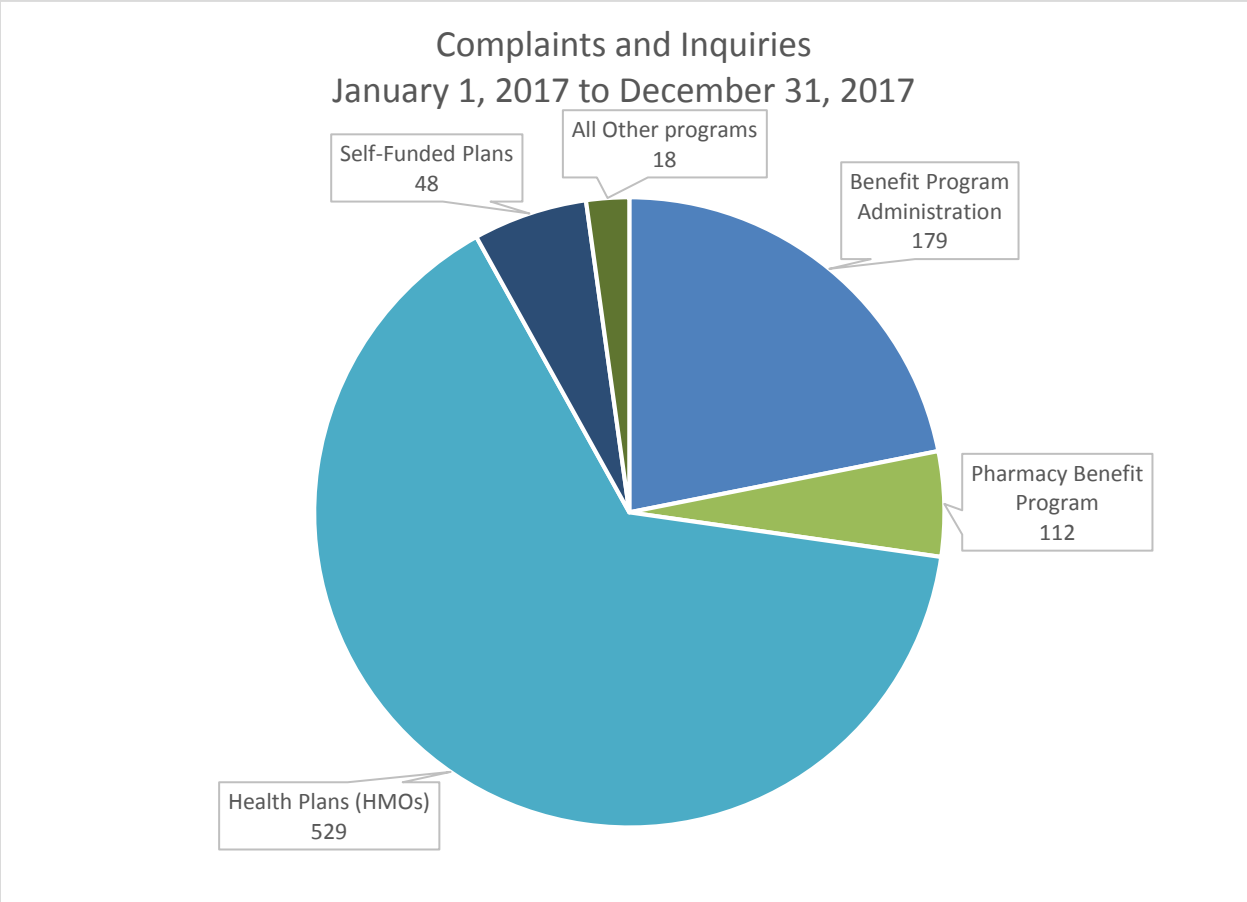
This report contains information about complaints and inquiries received by the Department of Employee Trust Funds (ETF) Ombudsperson Services staff. Complaints and inquiries are received from members, their families, employers and external advocacy organizations. All complaints are related to benefits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

From January 1 through December 31, 2017, Ombudsperson Services received 886 contacts involving complaints and inquiries from members or their representatives, a small decrease in comparison to 2016. During the same period, Ombudsperson Services received 45 written complaints, which have the potential to become Board appeals. Of these 45, nine were related to non-covered/excluded benefits, and seven to both general program provisions or design and enrollment and eligibility issues. The remainder were related primarily to plan service or administration.

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

David H. Nispel Electronically Signed 5/1/18

Board	Mtg Date	Item #
GIB	5.16.18	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.

Actions of health insurance plans generated most of the contacts with 529 complaints and inquiries, approximately 59% of the total. There were 519 contacts in 2016. Members with ETF benefit program administration issues resulted in the second largest number of contacts with 179, or 20% of the total. Most 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.

The majority of these contacts related to the following categories:

- General program provisions and design
- Enrollment and eligibility issues
- Non-covered or excluded benefits
- Claims processing and billing

Additional categories with noticeable complaint and inquiry numbers were:

- Plan service and administration
- Inquiries regarding exclusion of coverage for part of the wellness screenings

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 264 complaints and inquiries regarding Enrollment and Eligibility. The second highest complaint and inquiry category was General Program Provisions or Design with 179 contacts. The high number of contacts in these two categories is consistent with contacts received in 2016 and prior years. Other contact categories include Billing and Claims Processing (107 contacts), Non-Covered or Excluded benefits (97 contacts) and Plan Service or Administration (62 contacts).

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 contacts related to the increase in out-of-pocket (OOP) expenses for prescription drugs, which are attributable to the general program provisions rather than the pharmacy benefits manager.

Of 529 contacts related to the health insurance plans, 204 were Enrollment and Eligibility issues. The higher number of contacts related to Enrollment and Eligibility when compared with 2016 can be attributed to the large number of members who were forced to switch health plans for 2018. Many of these contacts took place coinciding with the beginning of the annual It's Your Choice open enrollment period. The substantial changes in the health plan networks, particularly in the southeast portion of the state, created difficulties for our members in finding new providers. This also accounts for the higher number of contacts (48) compared with 2016 (19) related to the self-funded plans as WEA took over administration from WPS for 2018.

Looking Ahead

During 2018, 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 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.