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Correspondence Memorandum

Date: July 25, 2018

To: Group Insurance Board

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

Subject: Semi-Annual Ombudsperson Contact Report
January 1 through June 30, 2018

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, 2018, Ombudsperson Services received 384 complaints and inquiries from members or their representatives, a decrease in comparison with the 444 received during the same period in 2017. Actions of health insurance plans generated most of the contacts with 211 complaints and inquiries, approximately 55% of the total. This compares with 255 such contacts during the first six months of 2017.

Members with ETF benefit program administration issues resulted in the second largest number of contacts with 99, or 26% percent of the total. Most of these contacts related to the health insurance program but involved complaints and inquiries that did not reflect any activity by the health plans. 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. Another example is contacts related to the increase in out-of-pocket expenses for prescription drugs which are attributable to the general program provisions rather than to action taken by the pharmacy benefits manager.

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

David H. Nispel Electronically Signed 7/31/18

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Ombudsperson Services also received 29 written health insurance complaints, which have more potential to become Board appeals. This compares with 20 received in the first six months of 2017, a 45% increase. The number reflects an upward trend in written complaints and in the complexity of complaints handled.

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

- General program provisions and design (138)
- Claims processing and billing (67)
- Enrollment and eligibility issues (48)
- Non-covered or excluded benefits (30)
- Access to providers (21)

Of particular interest are the number of contacts resulting from the reduction in the number of health plans offered. Many of these contacts took place in 2017 and coincided with the beginning of the annual open enrollment period. But, once the plans took effect January 1, however, other problems surfaced regarding contracted providers within the new plans that did not meet the member's needs. Late enrollment exceptions were granted through the end of February -- and in some special circumstances beyond -- to allow members to select a different health plan based on shifts in networks as plans initiated new provider contracts for the new year. These provider contract changes affected decisions made by members during open enrollment that were based on the information provided by the plans at that time. The changes in the health plan networks, particularly in the southeast portion of the state, created difficulties for some members finding new providers.

Ombudsperson Services staff continued to help members understand various aspects of their health insurance, including coordination of benefits, prior authorization requirements, and dental coverage. Due to the larger-than-normal changes in health plans offered, Ombudsperson Services assisted members who needed help transitioning to new providers. Most of those changes involved members with ongoing health problems requiring complex care. ETF established specific contacts with each health plan who were tasked with helping to coordinate transitions of care.

Looking Ahead

Complaints and inquiries related to the changes in health plans offered to members have already decreased; we expect that trend to continue as we move through the second half of the year. Ombudsperson Services also expects more inquiries about the new Medicare Advantage plan being offered in 2019. Staff will be involved in meetings related to the new Medicare Advantage plan information and rollout. This has provided us with the opportunity to have input into the mailings and information presented to our members, while ensuring we have the program knowledge required to best educate Medicare-Eligible retirees about its value for their needs.

Ombudsperson Services staff will be involved with preparations for the annual Its Your Choice (IYC) open enrollment activities, including review of the IYC member materials and participation in the IYC Member Communications Committee and Subcommittees. The goal is to enhance the clarity and quality of information provided to members. Staff will also be involved in the open enrollment Employer Kickoff event, internal staff trainings and employer health fairs across the state.

As always, we continue to emphasize early intervention in the resolution of all matters. Our goal is to keep the number of Board appeals low. As a result, our resources continue to stay focused 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.