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Correspondence Memorandum

DATE: April 17, 2020

TO: Group Insurance Board

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

SUBJECT: Annual Ombudsperson Contact Report
January 1 through December 31, 2019

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, 2019, Ombudsperson Services received 737 complaints and inquiries, a slight decrease in comparison with the 759 (-3%) received during the same period in 2018. But when looked at as a percentage of total health plan membership, the number is virtually the same as last year. Actions of health insurance plans generated most of the contacts with 411 complaints and inquiries, approximately 56% of the total. This compares with 409 such contacts during 2018, a slight increase.

Ombudsperson Services received 65 written health insurance complaints in 2019, which have the potential to become Board appeals. This compares with 55 received in 2018, an 18% increase. This number has steadily increased since 2015 when we received 23 written complaints and continues to reflect an upward trend in the complexity of complaints received.

After Ombudsperson Services completed their work on written complaints, there were nine requests for Departmental Determinations in 2019 and only one departmental determination appealed to the Board. This has reduced pressure on other agency staff, particularly in the Office of Strategic Health Policy (OSHP), who are focused on new programmatic commitments and initiatives. Ombudsperson services staff decreased from three to two, with James Kates' retirement in July, 2019.

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

David H. Nispel Electronically Signed 4/29/20

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Other member complaints with ETF benefit program administration issues 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. A few notable issues generating these complaints and inquires involved issues related to copays and deductibles, enrollment in Medicare upon retirement, counseling on appeals for denied procedures and help explaining program benefits.

The change in the contracted provider for pre-tax employee reimbursement accounts generated a number of complaints and inquiries as members moved from the TASC plan to ConnectYourCare® (CYC) . Staff worked with members on issues related to substantiating flexible spending account (FSA) claims and transitioning accounts to CYC.

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

- General program provisions and design (187)
- Claims processing and billing (138)
- Enrollment and eligibility issues (114)
- Non-covered or excluded benefits (98)
- Prior Authorizations (41)

Each of these categories and the individual complaints can involve multiple contacts with members, health plans, other ETF staff, and research to find a solution.

Ombudsperson Services staff were active participants in ETF's Member Communications Team meetings as well as the three work groups focused on printed materials, e-learnings, and website enhancements. The work accomplished by these teams provides our members with many options for clear, easily obtained information. Although it can lead to fewer contacts for general questions, the availability of information has also increased the complexity of the problems and questions Ombudsperson Services encounters. During open enrollment, staff participated in off-site benefit fairs to assist in explaining current benefits as well as upcoming changes.

Ombudsperson Services staff meet regularly with OSHP to share member concerns and discuss process improvements. Our attendance at the quarterly Council on Health Plan Improvement (CHPI) meetings also gives us perspective on the challenges facing the health plans as we provide recommendations for plan enhancements, especially in relation to complaints and inquiries that show an area where more clarity is needed for both members and the health plans. In addition, staff work with Employer Services and the Retiree Health Insurance Unit with enrollment questions and problems.

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

requirements, dental coverage, as well as grievance appeals and external review options. A part of our mission is using the initial complaint resolution as an opportunity to educate our members so they can avoid problems.

Looking Ahead

Complaints and inquiries related to the changes in health, dental and pre-tax plans offered to members continues at a steady rate. We continue to be involved with the information presented to our members and to assist them as they navigate the programs.

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 continued participation in the development of the printed and website information. 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 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.