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Correspondence Memorandum

Date: July 24, 2020

To: Group Insurance Board

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

Subject: Semi-Annual Ombudsperson Case Report 1/1/20 – 6/30/20

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. Please note that the name has been changed from "Contact" report to "Case" report to better reflect the complex nature of the complaints and inquiries, which were generated by members, their families, employers, and external advocacy organizations. They are primarily related to benefits under the authority of the Group Insurance Board (Board).

From January 1 through June 30, 2020, Ombudsperson Services handled 370 cases for members, a slight increase in comparison with the 364 handled during the same period in 2019. Actions of health insurance plans generated most of the cases, with 191 complaints and inquiries, approximately 52% of the total.

Members with ETF benefit program administration issues resulted in the second largest number of cases with 98, or 26% percent of the total, which is an increase of 10% over the previous year. Many of these relate 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. Inquiries and enrollment issues due to the new split contracts (family contracts with at least one person on Medicare and one not on Medicare) and the vendor transition from TASC to CYC in the Employee Reimbursement Accounts Program also added to this category increase.

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

David H. Nispel Electronically Signed 7/31/20

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Ombudsperson Services also received 19 written health insurance complaints, which have more potential to become Board appeals. This compares with 41 received in the first six months of 2019. While the overall number of cases increased, the number of formal written complaints decreased dramatically with the onset of the coronavirus pandemic. Such complaints are usually complex and require more time to review and respond, with the goal of resolution and education at the earliest levels of review.

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

- General program provision or design (111)
- Enrollment and eligibility issues (76)
- Non-covered or excluded benefits (58)
- Claims processing and billing (52)
- External review information (24)

The top five categories have shifted from previous years and align with program changes and benefit enhancements that can generate inquiries regarding general plan and benefit design (i.e. split contracts, bariatric services, gender confirmation services). Additionally, the increase in requests for external review information appears to reflect members becoming more educated on their benefits and right to reviews. Ombudsperson Services made efforts in the past year to promote the services we offer to help resolve member complaints or guide them through plan grievance, administrative review, and external review processes.

Ombudsperson Services continues to work with ETF's Retiree Health Insurance Unit and Employer Services to address members' and their dependents' compliance with the requirement to enroll in Medicare, when first eligible, upon or after retirement. If Medicare enrollment is not timely, it can have serious financial consequences. We work with members and plans to correct member enrollment, enlisting the help of specialists with the Board on Aging and Long-Term Care and the Office of the Commissioner of Insurance, when needed, to ensure claims are processed correctly. Past efforts within ETF are helping to make sure our members have the information they need to avoid this problem.

Ombudsperson Services received complaints showing a wide variety of processes that health plans were using to determine coverage for continuous glucose monitors. This benefit falls under the health plan provisions. Complaints and notifications of grievance appeals, as well as members progressing to external review, made it apparent that the application of this benefit was not consistent. We requested that the Office of Strategic Health Policy (OSHP) ask the health plans to provide information on what requirements the plan uses to process this benefit to gauge the variety and address the potential for clearer guidance on applying this benefit for our members.

Dental and oral surgical claims are increasing as the technology and complexity of the range of those services continues to evolve. It is notable that many of the rejected

claim issues could have been avoided with members or their providers obtaining proper pre-treatment estimates or prior authorizations from the insurers. Again, we explain the benefit and reasons for rejection, and use the opportunity to advise our members how to avoid these problems in the future. This year's IYC benefit books will have more detailed information on the dental plan benefits and guidelines.

Claims for out-of-network services can be very complex, particularly when specialized treatments for cancer or other medical conditions are needed, and providers are not available within the health plan's network. Ombudsperson Services works to educate both the member and, when needed, the health plan, regarding authorizations for care and appropriate billing when out-of-network care need has been established and authorized.

Twenty-nine complaints arose with the transition from TASC to CYC. The transition itself moved along with few issues, but the TASC run out of claims generated most of the complaint activity. The Federal regulations for Employee Reimbursement Accounts govern our response to these complaints, but the program manager has helped to ensure that members' accounts, substantiation requirements, and notifications were properly handled and documented, helping us to explain the requirements to the members. We also have found that employers do not always explain the options to maintain these accounts upon retirement, through the end of the calendar year so that retirees can make sure they can access the funds they have set aside while an active employee.

Regularly working with other agency staff, we strive to help members understand various aspects of their health insurance, including coordination of benefits, prior authorization requirements, and dental coverage, as well as all other WRS benefit programs.

Looking Ahead

This year has brought new challenges and new types of inquiries to Ombudsperson Services due to the coronavirus pandemic. Staff had been working from home, one day a week, for the past two years, so the transition to full time at home was smooth. Most resources needed were already available electronically, and we have worked to continue to collaborate with each other, as well as other ETF staff, to ensure continuity. New topics arising from the pandemic include questions regarding premiums when members cannot actually access health services, continuity of care or therapies when clinic sites are closed, and the ability to obtain needed prescriptions, in home services, and equipment safely.

We continue to emphasize early intervention in the resolution of all matters. One of our objectives 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 any questions.