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Correspondence Memorandum

DATE: April 20, 2021

TO: Group Insurance Board

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Office of Legal Services

SUBJECT: Annual Ombudsperson Case Report
January 1 through December 31, 2020

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, 2020, Ombudsperson Services received 695 complaints and inquiries, a slight decrease in comparison with the 737 (-3%) received in 2019. Actions of health insurance plans continued to generate most of the cases, with 342 complaints and inquiries, approximately 49% of the total. This compares with 411 such cases during 2019, 57% of the total, a significant decrease, and another product of a tumultuous year.

This decrease in cases attributable to specific health plans was balanced by an increase in general complaints and inquiries regarding program design. Cases in that category jumped from 129 in 2019 to 186 in 2020, a 44% increase. These are member complaints with ETF benefit program administration and include issues involving 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. Pandemic restrictions created access issues out of the control of the health plans, and we worked with the plans and members to provide guidance for needed care. A few notable issues generating these complaints and inquires related to copays and deductibles, enrollment

Reviewed and approved by David Nispel, General Counsel, Office of Legal Services
David H. Nispel Electronically Signed 4/30/21

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in Medicare upon retirement, counseling on appeals for denied procedures and help explaining program benefits.

Ombudsperson Services received 33 written health insurance complaints in 2020, which have the potential to become Board appeals. This compares with 65 received in 2019. This number has steadily increased since 2015 when we received 23 written complaints but decreased significantly last year during the pandemic.

After Ombudsperson Services completed work on written complaints, three members requested a Departmental Determination, none of which were 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 program commitments and initiatives. Two full-time Ombudsperson Services staff provide these services to our members and staff.

Cases involving flexible spending plans increased from 24 in 2019 to 57 in 2020, which was significant. The year began with complaints that included the transition to ConnectYourCare® (CYC) from TASC, continued as participants finalized their 2019 plan year claims with TASC, and increased as the pandemic directly impacted the ability to use the funds. Federal legislative changes instituted to mitigate the potential loss of these funds generated many inquiries as ETF adjusted the program guidelines for employers to accept changes.

Additional Federal legislation in late December, anxiety over the typically large Dependent Care accounts and how those changes will be incorporated into the ETF program, continue to generate complaints and inquiries. Also, administration of the year-end processes for unsubstantiated claims kept the rate of complaints high. Ombudsperson staff worked with the flexible spending account program manager to establish a grievance process as well as with other OSHP staff to share information on member dissatisfaction and communication improvements.

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

- General program provisions and design (260)
- Enrollment and eligibility issues (136)
- Non-covered or excluded benefits (91)
- Claims processing and billing (83)
- External review information (30)

The top five categories have shifted slightly from previous years, as stated in the 2020 Semi-Annual Case Report. Pandemic restrictions on in-person services created a shift in member concerns as both members and health plans adjusted. Delays of treatments, surgeries and other health services likely lowered the number of members requesting information on external reviews from 41 in 2019 to 30 for all of 2020. But that will likely increase as access to services and procedures is fully restored.

Mid-year changes to flexible spending plans, accessing benefits under reduced availability of providers, and more usage of telehealth increased the numbers of complaints and inquiries related to general program provisions and design, from 187 to 260. These were in addition to the program changes and benefit enhancements that usually generate inquiries in this category (e.g., “Medicare Some” split contracts, bariatric services).

We continue our efforts to promote Ombudsperson Services to employers and members to use our services to help resolve member complaints or guide them through plan grievance, administrative review, and external review processes. During a year upended by COVID-19, the availability of an ombudsperson to assist, explain and guide members was a welcome benefit for many who were previously unfamiliar with the program.

Individual complaints in each of these categories typically involve multiple contacts with members, health plans, other ETF staff, other State agencies and/or research to find a solution.

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 ETF’s Employer Services Section Insurance Unit with enrollment questions and problems.

Ombudsperson Services staff actively promote benefit improvements when member dissatisfactions with program design arise. Our input into upcoming benefit changes or guidance to clarify access to benefits include:

- The coverage of Continuous Glucose Monitors (CGM’s) and related supplies, currently covered by the durable medical equipment provision for the device and the pharmacy benefit for the supplies, will change to coverage for both under the pharmacy benefit for the 2022 plan year if approved by the Board. This will ensure that both the brand of device and its associated supplies follow the same formulary. This improvement will dramatically lessen coverage issues encountered when the health plan and pharmacy plan formularies of covered brands did not align.
- Coverage of tooth-colored composites for fillings on all teeth. Previously, posterior teeth fillings had to be metal to provide the full dental benefit coverage. Many complaints arose because most dentists no longer use metal fillings, so the member had no choice but to accept the lesser coverage. This coverage may be updated for 2022 if approved by the Board.

- Adding coverage for orthognathic surgery when medically necessary, if approved by the Board. This benefit has been the subject of grievances, complaints, and correspondence to the Group Insurance Board over the last several years. The current Uniform Benefits general exclusion does not differentiate between a medically necessary need and a cosmetic need, thereby preventing members from obtaining coverage.
- Medicare members being removed from ETF-sponsored plans due to high-pressure sales or inadvertently agreeing to a move without proper information created a cascade of events through Medicare and the health plans, often resulting in unexpected financial consequences and lost benefits. Unwinding these cases can take months and create incredible anxiety for our elderly members. This is a problem affecting all the health plans but is more complicated when it involves the Medicare Advantage Plan, provided by UHC, due to the federal rules regarding Advantage Plan enrollments. Ombudsperson services asked UHC if there was something that could be done to alert members when they found them enrolling into one of their individual Advantage Plans and leaving the ETF-sponsored plan, before it became a crisis issue. UHC has created a notification process and personally calls affected members to make sure that this was their intention. It has already proved effective in avoiding this problem.
- Telehealth use increased dramatically in 2020 and resulted in inconsistencies in how the health plans applied the benefit. Complaints increased indicating the need for clarification and uniform guidance, which is currently being addressed by OSHP.

The 2020 plan year brought new challenges and new types of inquiries to Ombudsperson Services, due to the coronavirus pandemic. Staff transition to full time at home remains effective and the ability to engage with other staff and health plans remotely has been 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 access health services, continuity of care or therapies when clinic sites are closed, and the ability to safely obtain needed prescriptions, in home services, and equipment.

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.