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Correspondence Memorandum

Date: July 23, 2021

To: Group Insurance Board

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

Subject: Ombudsperson Services Semi-Annual Case Report
January 1 – June 30, 2021

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. Case files are created to address the complaints and inquiries, which are reported by active members, retirees, their families, employers, and external advocacy organizations. They are primarily related to benefits under the authority of the Group Insurance Board (GIB) and the majority involve health plan-related complaints. However, any dissatisfaction or inquiry regarding any WRS benefit can be addressed through Ombudsperson Services.

From January 1 through June 30, 2021, Ombudsperson Services received 392 complaints and inquiries from members or their representatives, an increase of 22 over the same period in 2020. Actions of health insurance plans generated most of the cases with 214 complaints and inquiries, approximately 55% of the total. This is a 5% decrease in health plan complaints compared to the same period in 2020. The increases in complaints in other areas show breadth of service requests across all programs, many of which were the result of recently created programs, such as the Supplemental Dental programs which began in 2019, changes to existing programs and adjustments made due to the pandemic.

Members with ETF benefit program administration issues and pharmacy benefit problems generated the second largest number of cases with 66 (17% of the total) for

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David H. Nispel Electronically Signed 08.09.21

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each program. This is a significant decrease from the 98 ETF program administration complaints for 2020 (-32%). These cases can involve the health insurance program but do 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.

During the six-month period, pharmacy benefit complaints increased from 24 to 66 (+175%). Many of these complaints were the result of formulary changes or problems with our Medicare-eligible members who are on Part D. Medicare-eligible members can experience significant difficulties with disenrollment from the pharmacy benefit generated by Medicare notifications of other coverage. This can happen through rather innocent inquiries turning into unintended acceptance of another plan and can take months to untangle, and often involve ETF's Employer Services Section, Navitus, and the Board on Aging and Long-Term Care (BOALTC). We are working with ETF's Pharmacy Benefit Program Manager to establish a Navitus liaison with specialized knowledge of the Medicare Part D program to help us resolve these issues more quickly.

Another driver of case increase has to do with our members understanding how the pharmacy benefit works when they move from a commercial plan (non-Medicare) to the Medicare RX Part D plan. We are working with the Offices of Strategic Health Policy (OSHP) and Communications to add cautionary notices to members transitioning to Medicare informing them to check with Navitus about how their coverage may change and to their physician if modifications to prescriptions are required to avoid needless expense and frustration.

The third largest number of cases involved the Employee Reimbursement Account programs. Ombudsperson Services received 55 cases; an 89% increase compared with the first six months of 2020. The closeout of TASC, along with the end of the first plan year for CYC, created many challenges. The end-of-year substantiation process differed significantly from prior years, including wage garnishments beginning in January and February for unsubstantiated claims. Inadequate information and confusing processes to provide substantiation in a timely manner created hardship, irritation, and many complaints. Properly substantiated funds were not made available or refunded to some members until late May or early June. Changes allowed by Federal legislation to provide more flexibility in carryovers and use of funds from 2020 were implemented in late May, as soon as the GIB approved them. Members who were eligible appeared to have success in adjusting their accounts.

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

- General program provision or design (102)
- Enrollment and eligibility issues (88)
- Non-covered or excluded benefits (46)

- Claims processing and billing (41)
- Unsubstantiated Claims (35)

The top five categories remained the same as 2020, with one exception. Unsubstantiated Claims issues involving the Employee Reimbursement Accounts (ERA) replaced Requests for External Review Information as the fifth highest complaint type. Many general program provision complaints were related to program guidelines for use and coverage of telehealth. Telehealth services, which are a covered benefit, had a large increase in use during 2020 when many in-person appointments were not available. Denied claims began to surface in late 2020, and it was determined that the benefit lacked detail and resulted in plans treating coverage of these claims differently. Complaints coming into Ombudsperson Services revealed the need for telehealth benefit clarification, which was communicated to OSHP staff. This became a topic of discussion with the health plans through the Council on Health Program Improvement (CHPI) meetings and surveys of how the plans applied the benefit, resulting in new program guidance for the 2022 plan year.

The number of requests for external review information stayed consistent throughout the pandemic but mainly involved pharmacy benefit appeals. Assistance for members will likely continue to increase in number as medical services delayed due to the pandemic rebound. Ombudsperson Services continues their efforts to promote the services we offer to help resolve member complaints or, if necessary, guide them through plan grievance, ETF Administrative Review, and external review processes.

Looking Ahead

The first six months of this year brought several challenges for Ombudsperson Services as we worked to resolve member cases. Conflicting information that members experienced, in part due to the pandemic, formulary changes mid-year, and new processes associated with the Employee Reimbursement Accounts increased the numbers of cases handled.

Providing education to members about how best to access their benefits during these changing times in health care has been a primary focus for Ombudsperson Services. In addition, staff will be working with Office of Strategic Health Policy on improvements to the Connect Your Care communications regarding the ERA substantiation process.

We will also be monitoring cases that involve Continuous Glucometer Monitors and the change in coverage for 2022, along with the newly added Orthognathic Surgery benefit and acupuncture.

In 2021, ETF has provided guidance to health plans regarding coverage of telehealth services and when and if a copayment should be applied. Ombudsperson Services will continue to monitor member contacts and ensure members are able to obtain telehealth benefits under the Uniform Benefits contract.

Ombudspersons have been working from home since mid-March 2020 and will continue to provide services via hybrid remote working, primarily working from home, with occasional in-person work at Hill Farms State Office Building. Work from home continues to be smooth and very few processes that Ombudsperson Services is involved in required changes. Most resources needed were already available electronically, and we have worked to continue to collaborate with each other daily, as well as with other ETF staff, to ensure continuity for our members.

Staff will be available at the Board meeting to answer any questions.