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Correspondence Memorandum

Date: April 11, 2022

To: Group Insurance Board

From: Liz Doss-Anderson, Ombudsperson
Mary Richardson, Ombudsperson
Office of the Secretary

Subject: 2021 Annual Ombudsperson Case Report

This memo is for informational purposes only. No Board action is required.

This report contains information about cases generated by complaints and inquiries received by the Department of Employee Trust Funds (ETF) Ombudsperson Services (OS) staff. These 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). In 2021, we assisted 368 annuitants and their dependents, and 332 employees and their dependents. The remaining members were either continuants or other non-WRS individuals. Beginning in 2021, we began collecting information on whether complaints were generated by State or Local annuitants, active employees, or their dependents. Many Local employers have a small number of employees enrolled in our plans. This additional differentiation between State and Local can help inform us where there may be a need for more employer training or resources for employees and their families.

From January 1 through December 31, 2021, OS handled 724 cases, a slight increase of 4.5% from the 695 received in 2020. A total of 344 cases (48% of the annual total case load) were related to health insurance, which is comparable to the prior year.

Cases involving program design are member complaints about 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 uniform contract provisions. Program design cases decreased from 186 cases in 2020 to 144 cases in 2021, a 22% decrease, which we believe can be attributed to continued efforts to educate our members.

Reviewed and approved by Pamela Henning, Assistant Deputy Secretary
Electronically Signed 05/02/2022
Pamela L Henning

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Other notable changes show increases in complaints and inquiries for the pharmacy benefits program. There was a total of 111 cases in 2021, which is up from 62 cases in 2020, a 79% increase. Pharmacy Benefit cases can involve drug tier changes, medications no longer on the formulary, or name brands replaced by generics. These changes require members to obtain a different prescription or follow other processes to continue to access a preferred or better tolerated medication or request lower copays.

The increase in Employee Reimbursement Account cases is associated with two primary sources. First, the 2021 Unsubstantiated Debt process and procedures for substantiation and recoupment of funds, resulted in 78 contacts in 2021. In comparison, since January 2022, we have opened only two cases related to Unsubstantiated Debt. The new substantiation process includes more information for members, reminders to provide documentation and the ability to send documentation through the Optum online portal. Efforts were made by OS, the Office of Strategic Health Policy (OSHP), and others within the agency to educate affected members and explain changes to the Unsubstantiated Debt process. We continue to monitor their progress in addressing this issue. Second, we opened approximately 15 cases involving allowable mid-year election changes due to the pandemic. These cases related to the short timeframe for rolling out guidance, which resulted in members not being aware of the opportunity to change their elections. Working with Optum and Department staff we were able to resolve several of these complaints in favor of the member.

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

- General program provisions and design (201)
- Enrollment and eligibility issues (144)
- Non-covered or excluded benefits (86)
- Claims processing and billing (83)
- External review information (44)

Other notable issues generating complaints and inquiries were related to copays and deductibles, enrollment in Medicare upon retirement, help explaining program benefits and counseling on the grievance process at the plans for denied procedures or eligibility.

Written health insurance complaints have the potential to become Board appeals, of which OS received 28 written complaints in 2021 compared to 33 received in 2020. After OS completed work on these written complaints, three members requested Departmental Determinations from OSHP and two are being appealed to the Board. Efforts by OS continues to reduce the number of Determinations requested by members, thereby allowing other agency staff, particularly in OSHP, to focus on new policies, programmatic commitments, and initiatives.

Looking Ahead

The second half of 2021 included OS's continued efforts to provide recommendations for improving member communications. In collaboration with OSHP and the Office of Communications, we will add a new landing page on the ETF web site that provides a central location for information about the grievance processes at our different plans. This new resource will benefit members, employers, and staff with easy to access, valuable grievance information.

Our collaborations with other ETF business units and other State agencies to resolve member issues continues to prove productive. OS also monitors trends in complaint issues, which can inform future benefit changes or provide discussion points useful to OSHP as well as the Council on Health Insurance Program Improvement meetings.

OS has recently transitioned from the Office of Legal Services to the Office of the Secretary. This change provides a level of independence to the program as recommended by the industry. The team consists of two full-time Ombudspersons providing these services to our members, employers, and staff.