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# *Correspondence Memorandum*

**Date:** July 19, 2024

**To:** Group Insurance Board (Board)

**From:** Liz Doss-Anderson, Ombudsperson
Peggy McCullick, Ombudsperson
Office of the Secretary

**Subject:** 2024 Semi-Annual Ombudsperson Services Case Report

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

This report contains information about cases handled by the Department of Employee Trust Funds (ETF) Ombudsperson Services (OS) staff between Jan. 1, 2024, and June 30, 2024. Case files are created to address complaints and inquiries reported by active members, retirees, their families, employers, and external advocacy organizations. Cases are primarily related to benefits under the authority of the Board, and the majority involve health plan-related complaints. However, any dissatisfaction or inquiry regarding any Wisconsin Retirement System (WRS) benefit can be addressed through OS.

In the first half of 2024, OS opened 330 cases/inquiries from members or their representatives, a decrease of 86 over the same period in 2023 (Ref. GIB | 11.15.23 | 14B). Actions of health insurance plans generated most of the cases, approximately 55% of the total. The most frequent cases came from state retirees or their dependents with 150 contacts, state active employees and their dependents with 159 contacts, and local active employees and retirees with 21 contacts.

The top four complaint types opened from Jan. 1 through June 30 this year were related to the following complaint type categories:

- Billing and Claims Processing Errors (78)
- General Program Provision or Administration of Benefits (44)
- Independent Review Requests (73)
- Enrollment and Eligibility (30).

The largest complaint category was “Billing and Claims Processing Errors” with 78 contacts. Additionally, there were 44 “General Program Provision or Administration of

Pamela J Henning

Reviewed and approved by Pam Henning, Assistant Deputy Secretary
Electronically Signed 07/31/2024

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Benefits" cases. These inquiries often involve clarification of benefits and members advocating for changes to Uniform Benefits or eligibility for benefits. In the first half of 2024, cases involving "Billing and Claims Processing Errors" had an increase of 11 contacts compared to the same period in 2023. In contrast, contacts under the "General Program Provision or Administration of Benefits" category decreased by 75 cases between the first half of 2024 and the same period in 2023.

OS continues to monitor cases involving Employee Reimbursement Accounts (ERA), which is administered by Optum Financial (Optum). In the first six months of 2024, OS opened 29 cases involving ERA programs. This is a decrease of 8 cases from the same period in 2023 in which OS opened 37 cases. Over the last several months, OS has been working with Office of Strategic Health Policy (OSHP) on an initiative to improve our website's ERA pages. To improve member experience, OS has included more information about the unsubstantiated claims process, a link to the manual claim form for Optum, and contact information including Optum's mailing address for our member who may not have online access to the Optum portal.

Some cases involve education of members regarding GHIP programs who have experienced a plan denial of a service or procedure and eligibility issues. OS staff also explain how plans use medical management criteria within Uniform Benefit guidelines and how to request reviews of denials. This typically includes substantial time counseling members on how a plan grievance process works, what to expect as they go through the process, and their rights, depending upon the grievance outcomes.

OS staff educate members on how to advocate for themselves or family members, how to ask their providers for help in demonstrating medical need, and their rights for independent reviews or for ETF departmental review. Providing support to members by educating them on the strongest justification for their complaint and appeals process is an important service offered by OS staff. OS staff also explain outcomes of plan grievances and options available to members participating in the appeals process, including how a negative outcome has been justified by the plan.

Members contact OS for assistance in locating payable providers in their plan's service area or requesting exceptions to their network. Many members are waiting three to four months to see their primary care physician and six to twelve months for many specialty care providers such as behavioral health, dermatology, and vision care.

Working with our partners (health plans, employers, other ETF staff, and drawing in expertise from other state agency staff, when needed), OS staff collaborate to attempt to resolve member issues before they reach the appeal process. If OS staff are unable to resolve an issue on behalf of a member, members are advised of their additional avenues of appeal or resources.

**Looking Ahead**

As OS staff move into the 2025 It's Your Choice open enrollment period, OS anticipates escalated calls related to changes to existing plans' networks (including network name changes) and requirements for new plan prior authorizations. OS staff will be working with various areas of ETF to help ensure that members who will need to transition to new plans have the resources available to them to make an educated decision. As members of the open enrollment project team, OS advocates for improvements in open enrollment communications and how to transition from one plan to another. This includes information on the ETF website, the Open Enrollment Decision Guides, and planned webinars during the period.

In 2025, OS staff will also continue to look for opportunities to increase the visibility of the OS program and the services we provide. These include adding additional easy-to-find links on the ETF website for OS information, links to resources related to plan grievance process, the ETF Administrative Review process, improvements to our ERA program web pages. In addition, we will provide outreach and education to the Board on Aging and Long-Term Care staff on our health insurance program, including sick leave, transitioning from active to retiree coverage and appropriate referrals to OS.

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