STATE OF WISCONSIN
DEPARTMENT OF EMPLOYEE TRUST FUNDS
801 West Badger Road
Madison, WI 53702

CORRESPONDENCE MEMORANDUM

DATE: May 12, 2003

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson, Quality Assurance Services Bureau
Christina Licari, Ombudsperson, Quality Assurance Services Bureau

SUBJECT: Employee Trust Funds (ETF) 2002 Complaint Report

This report is provided for informational purposes and provides information regarding health and disability insurance complaints received by the Department in 2002. This report is used to monitor trends and address emerging issues in the health and disability programs. A summary chart of some of this data will also be included in the Report Card section of the *2004 It's Your Choice* booklet.

I. 2002 ETF Complaint Activity Report

This report provides summary data on complaints processed by the Department in calendar year 2002. As in past years, the Department collected information regarding formal written complaints submitted to the Department for administrative review. Beginning in June 2002, the Department also began collecting data on informal complaints. Informal complaints are primarily received over the phone and are typically resolved within one week. This type of complaint frequently involves issues such as difficulties with the referral process, enrollment and eligibility issues and claims processing problems. In addition, staffing changes allowed us to develop a more formalized process for tracking disability complaints, as reflected in this report.

This report includes information on both formal and informal complaints regarding the health insurance and disability programs. While the number of new formal health insurance complaints received by the Department declined in 2002, the total number of complaints handled by the Quality Assurance Services Bureau staff was 244.

A. *Health Insurance Complaints:*

Some highlights regarding formal health insurance complaints received by the Department in 2002 include:

- Standard Plan complaints continued on a steady decline, accounting for 23% of new formal complaints. In 2001, 27% of new complaints were about the Standard Plans, and in 2000, that number was 43%. The majority of Standard Plan complaints concern denials involving medical necessity, non-covered services and usual, customary and reasonable (UCR) payments.

- In 2002, there were no ETF complaints for Atrium, Group Health Cooperative-Eau Claire, Medical Associates and Mercy Care.
- CompcareBlue (all plans combined) and Humana (Eastern and Western combined) stand out as having the highest number of managed care complaints with each having approximately 16% of new formal health insurance complaints filed by members.
- The three most common complaint types for managed care plans were billing issues involving incorrectly submitted claims and provider discounts, non-covered services and unauthorized services.
- Active state employees registered the most complaints (60.6% of total complaints), almost half of which were filed by University of Wisconsin employees. Annuitants accounted for 33% of new complaints and local employees accounted for 3%.
- Of the 173 complaints closed in 2002, 48% were resolved in favor of the member through compromise. Of these, 8% were closed through the plan grievance process with a favorable resolution. This is evidence of the continued need to educate participants on how to successfully work with their health plan to resolve issues before contacting ETF.
- We continue to receive general complaints regarding issues such as dental coverage (e.g., lack of uniform dental coverage and availability of dentists), lack of preferred provider plan options, premium increases, weight loss surgery benefits, and proposed changes in the health insurance programs.

B. *Disability Complaints:*

Formalized statistical tracking of disability complaints began in July 2002. The 47 complaints logged in this area include Income Continuation Insurance (ICI), Long-term Disability Insurance (LTDI), § 40.63 and § 40.65 complaints. Currently, there is no distinction made between formal and informal complaints, as disability complaints are typically urgent in nature and handled on a priority basis by staff.

Unlike health insurance complaints, disability complaints may occur at any stage of a disability benefit claim. It is possible for an ICI complaint, for example, to occur during the initial claim process or after the claim has ended and an overpayment is discovered. The ETF ombudsperson serves as a liaison, working collaboratively with the contract administrator (CORE, Inc.), the ETF Disability Programs Bureau, employers and medical providers to advocate for members and resolve complaints.

Observing and tracking trends in disability complaints allows ETF staff to educate participants, as well as provide feedback to CORE regarding training and service improvement needs. Complaint statistics reveal that the most frequent ICI complaint types were plan service and administration, billing/claim processing and overpayments.

- ICI plan service and administration complaints consist largely of issues involving delayed or missed payments or poor customer service. ETF staff noticed an improvement in the frequency and severity of these types of complaints between the time complaint tracking began in July 2002. Over the past several months, members have remarked that even though CORE staff may not have been able to resolve their

problem, the communications they had with CORE were polite, professional and demonstrated a desire to assist the member.

- ICI billing/claim processing complaints are typically generated during the initial claim process. The obstacles and delays inherent to the ICI claim process, such as obtaining employer certifications and attending physician statements, are often the cause of complaints. This type of complaint is generally resolved through coordinated efforts to obtain necessary information to process the claim. ETF ombudsperson and disability staff regularly verify that CORE is adhering to the ICI contract regarding claim processing and notification standards.

- ICI overpayment complaints are the result of the discovery of erroneous payments to ICI members. Erroneous payments occur when the incorrect benefit amount is paid or when a claimant returns to work without notifying CORE or ETF and continues to receive benefits that are not due. The majority of these complaints are resolved with ETF ombudsperson intervention and now result less frequently in requests for further administrative review.

ETF ombudsperson staff routinely educate members regarding disability benefit program design, assist members in navigating the disability claim process and advise members of subsequent administrative review rights. In addition, ombudsperson staff participate in weekly operations teleconferences between CORE and members of the Disability Programs Bureau in an ongoing effort to improve service to our members and keep abreast of emerging issues or potential program problem areas.

Attached you will find several charts which depict ETF health insurance (formal and informal) and disability complaint activity. The health insurance charts include a comparison of complaints received and closed, new complaints received in 2002 compared to previous years and complaint activity by plan. The disability charts include complaint data from the last half of 2002 regarding complaint types and resolutions.

II. Health Insurance Complaint Standards

The 2001-2003 Biennial Budget paper stated that the optimal complaint backlog would be 20-30 open complaints at any given time. To help address the high backlog of complaints, Liz Doss-Anderson was hired in December 2001, and Christina Licari was hired in July 2002 to act as ombudspersons for participant complaints. As a result, the backlog of open health insurance complaints has been steadily decreasing from a high of 108 in October 2001 to 62 in April 2002 and, most recently, 21 at the end of April 2003.

In addition, internal complaint processing standards were developed to ensure budgetary goals were being met. These standards include acknowledging receipt of a complaint within 5 working days, and health plan response to a complaint received within 15 working days. Progress on meeting these new standards is as follows:

- New complaints received were acknowledged within 5 working days 92% of the time, with 12 (8%) of the complaints being acknowledged beyond the goal of 5 days. These delays

primarily occurred when a complaint was forwarded within the Department from another area or when a complaint was initially handled as an informal complaint.

- The internal standard requiring health plans to respond to the Department's request for information within 15 working days was met 66% of the time by more than half of the health plans. In 2002, Blue Cross Blue Shield United of Wisconsin, CompcareBlue North, Dean and Humana each had 10 or more complaint responses that were received beyond the standard of 15 working days. The health plan's response time continues to be monitored by ETF staff and when necessary, appropriate action is taken to re-educate health plans on the Department's expectations.

III. ETF Health Insurance Complaint Survey

In 2001, as part of customer service initiatives for the Department, we began surveying complainants after an ETF ombudsperson completed the complaint review. A copy of the survey is attached. Last year's survey data was based on a six-month period, and the data collection continued in 2002. The total response rate of members completing the survey in 2002 was 62%.

The following depicts the percentage of respondents answering "strongly agree," "agree" or "somewhat agree" to the following questions:

	2001	2002
1. My complaint was handled in a timely manner.	75%	62%
2. The ombudsperson was professional and courteous.	89%	92%
3. The assistance provided by the ombudsperson was helpful.	79%	73%
4. Regardless of the outcome, the complaint process provided an adequate opportunity to favorably resolve my complaint.	74%	73%
5. The information provided by the ombudsperson and the responses to my questions were precise and understandable.	85%	79%
6. Regardless of the success in resolving my complaint, I found the knowledge and assistance from ETF to be a valuable benefit.	73%	74%

In general, members are satisfied with the ombudsperson services offered through ETF. As expected, the high backlog numbers during most of 2002 contributed to the decreased satisfaction in the area of timely review of complaints. We will continue to send surveys out to all members using the ombudsperson services through the formal complaint process at ETF. We believe it is a valuable tool as we continue to evaluate how we can best serve our members.

If you have any questions about the information provided, we will be available at the Board meeting. Thank you.

Attachments