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CORRESPONDENCE MEMORANDUM

DATE: May 18, 2005

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) 2004 Insurance Complaint Report

This report is provided for informational purposes only. It contains information regarding health insurance, disability insurance and pharmacy benefit manager (PBM) program complaints received by the Department in 2004 and is used to monitor trends and address emerging issues in the insurance programs. A summary of select data will also be included in the Report Card section of the *2006 It's Your Choice* booklet.

2004 ETF Complaint Activity Report

Below is a summary of information regarding complaints processed by the Department in calendar year 2004. As in past years, the Department collected information regarding formal written complaints submitted to the Department for administrative review. The Department also collected 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 referral process difficulties, enrollment and eligibility, and claims processing.

This report includes information on both formal and informal complaints regarding all insurance programs. The total number of new complaints opened across all program types increased in 2004 to 877 compared to 428 in 2003. This significant increase can be partially attributable to the implementation of a single PBM effective January 2004. While the Department worked closely with Navitus Health Solutions (Navitus) to minimize the impact of implementation by various means of outreach and education, many complaints involved member dissatisfaction with the criteria required for an approval of a reduced copayment (Level 3 medication at a Level 2 copayment). In addition, the new requirement that state employees contribute toward their health insurance via the three-tier premium structure resulted in a variety of complaints from members and employers.

The number of complaints handled informally by staff continued to increase and members responded favorably to complaint/issue resolution with this faster more efficient method. Informal handling of complaints often eliminates the need for further administrative action by either the plan or the Department. In addition, staff monitored informal complaint activity to identify trends and areas of concern so emerging issues could immediately be addressed.

Reviewed and approved by Pam Henning, Administrator, Division of Management Services.

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Signature Date

Board	Mtg Date	Item #
GIB	6/21/2005	

A. Health Insurance and Pharmacy Benefit Complaints

Some highlights regarding health insurance complaints received by the Department in 2004 include:

Formal Complaints

- In 2004, there were no ETF complaints filed by members regarding either Group Health Cooperative-Eau Claire or Medical Associates.
- Dean Health Plan, whose enrollment is nearly 24% of our total contracts, received only 4% of our total complaints.
- The new PBM that provides pharmacy benefits for 99.7% of our total contracts, received the most new formal complaints in 2004, with 102 complaints. Humana Eastern, whose enrollment is 6.7% of total contracts, had the most complaints with approximately 10% of new formal health insurance complaints.
- The three most common complaint types were denials of excluded or non-covered benefits (22%), general program provision or design (18%), and denials of requests for copayment reduction for prescription drugs (12%).
- Of the 201 formal complaints closed in 2004, 60% were resolved in favor of the member. Of those resolved in favor of the member, 27% were closed in the member's favor through the plan grievance process with ETF intervention. This is a 12% increase over last year and continues to support the value of utilizing the ombudsperson services and the grievance process through the plans.

Informal Complaints

- The three most common types of informal complaints were enrollment and eligibility (21%), general program design (21%), and billing and claims processing (20%), totaling 62% of all informal complaints. As expected, a significant number of the enrollment and eligibility complaints occurred during the first two months of 2004. In addition, the majority of the general program provision or design complaints were related to the change to the single PBM, which required all members to utilize a new three-level formulary that was established by Navitus.
- Complaints related to denials of prior authorization requests (7%) and referral requests (6%) accounted for 13% of all informal complaints. The Department will continue efforts to educate members on the most effective ways to navigate the system and to work with their health plans to obtain benefits to which they are entitled.

B. Disability Complaints

The Department logged 176 disability benefit complaints, which included complaints or inquiries related to Income Continuation Insurance (ICI), Long-Term Disability Insurance (LTDI), § 40.63 disability retirement and § 40.65 duty disability programs. There is no distinction made between formal and informal complaints, as disability complaints are typically urgent in nature and are, therefore, handled on a priority basis.

Disability complaints may occur at any stage of a disability benefit claim. Included in the total number of complaints are all inquiries made to ETF regarding disability benefit structure or specific claim questions. The ETF ombudspersons serve as liaisons, working collaboratively

with the contract administrator (Broadspire), 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, provide feedback to Broadspire regarding service improvement needs and recommend changes to written materials.

- The total number of complaints received by ETF in 2004 was 176, compared to 124 in 2003. Increased awareness of the ombudsperson services offered at ETF may have contributed to this increase. In addition, in prior years, ETF tracked only contacts in which the member expressed dissatisfaction. However, beginning in 2004, all contacts were tracked in order to better understand the nature of members' questions and help identify possible areas for additional outreach or educational efforts.
- 60% of complaints received were resolved/closed as inquiry only, 20% in favor of the member, 14% as no change and 6% as compromise.
- The most frequent ICI complaint types in 2004 were overpayments (31%), initial claim processing (11%), and payment or check error (11%).
- Overpayment complaints decreased to 31% in 2004, down from 41% in 2003. Broadspire completed 538 overpayment calculations in 2004, compared to 703 in 2003. Overpayments are typically caused by retroactive awards of benefits that are required to be offset against the ICI program, such as other Wisconsin Retirement System benefits, Workers Compensation, and Social Security Disability Insurance.
- There were no plan service and administration complaints in 2004. This continues a three-year decline. In 2002, 32% of all complaints were related to plan service and administration. While the number of complaint/contacts ETF received in 2004 was higher than in 2003, the nature of the complaints was no longer related to the quality of service members received.

ETF ombudsperson staff routinely educate members regarding disability benefit program design, assist members in navigating the claim process and advise members of administrative review rights. In addition, ombudsperson staff participate in weekly operations teleconferences between Broadspire and 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 tables and charts reflecting ETF health insurance (formal and informal) and disability complaint activity for 2004.

Health Insurance Complaint Standards

The optimal complaint backlog for health insurance complaints at any given time is to be between 20-30. Over the last several years the backlog of open health insurance complaints has steadily decreased from a high of 108 in October 2001 to a low of 15 in January 2004. During the first half of 2004, the backlog increased beyond our standard 30 open complaints to a high of 47 in May 2004. This increase was a result of a higher number of informal complaints, which required immediate attention, during the implementation of the PBM. As of April 30, 2005, the complaint backlog was again within the goal of 20-30 complaints, with 28 formal complaints open and awaiting review.

In addition, internal complaint processing standards were developed to ensure operational goals were met. These standards include acknowledging receipt of a complaint within five working

days, and requiring a health plan response within 15 working days. Progress on meeting these new standards is as follows:

- In 2004 new complaints were acknowledged within five working days 90% of the time, with nine of the complaints being acknowledged beyond the goal of five days. These delays primarily occurred when a complaint was forwarded within the Department from another area or when the ombudsperson attempted to resolve the complaint informally, prior to a formal acknowledgement letter being sent to the member.

- The compliance rate for receipt of plan response within 15 working days was improved to 90% in 2004, compared to 83% in 2003. Health plan response time is regularly monitored by ETF staff and contact is made with individual health plans when action is needed to re-educate the plan on the Department's expectations.

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. The 2004 survey response rate was 71%, with 102 surveys returned by members.

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

		2003	**2004**
1.	My complaint was handled in a timely manner.	85%	74%
2.	The ombudsperson I had contact with was professional and courteous.	98%	97%
3.	The assistance provided by the ombudsperson was helpful.	59%	78%
4.	Regardless of the outcome, the complaint process provided an adequate opportunity to favorably resolve my complaint.	69%	68%
5.	The information provided by the ombudsperson and the responses to my questions were precise and understandable.	85%	78%
6.	Regardless of the success in resolving my complaint, I found the knowledge and assistance from ETF to be a valuable benefit.	73%	76%

In general, members are satisfied with the ombudsperson services offered through ETF. We will continue to send surveys out to all members using the ombudsperson services through the formal complaint process at ETF. In addition, 2005 surveys will be mailed to disability insurance complainants, as we believe it is a valuable tool 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