AGENDA AND NOTICE OF MEETING

STATE OF WISCONSIN
GROUP INSURANCE BOARD MEETING

Tuesday, November 11, 2008
9:30 a.m.

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

Documents for this meeting are available on-line at:
http://etf.wi.gov/boards/board_gib.htm
To request a printed copy of the agenda items, please contact
Sharon Walk, at (608) 267-2417.

Times shown are estimates only.
Announcements
⬅ *Denotes action item.*

9:30 a.m. ⬅ **1. Consideration of Minutes of August 26, 2008, Meeting**

9:35 a.m. ⬅ **2. Consideration of Surviving Insured Dependent Rule**

9:40 a.m. ⬅ **3. Consideration of Legal Services Payroll Deduction**

10:00 a.m. **4. Miscellaneous**

- Budget Update
- Local Annuitant Health Plan (LAHP) 2009 Rates
- Other Optional Plans
- Dual-Choice Update
- Correspondence/Complaint Report
- Pending Appeals Report
- 2008 Fact Sheets
  - State Income Continuation Insurance Program
  - Local Income Continuation Insurance Program
  - Ombudsperson Services Program
- Items for Future Discussion

10:15 a.m. **5. Adjournment**

The meeting location is handicap accessible. If you need other special accommodations due to a disability, please contact Sharon Walk, Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931. Telephone number: (608) 267-2417. Wisconsin Relay Service 7-1-1. e-mail: sharon.walk@etf.state.wi.us.

MINUTES OF MEETING

STATE OF WISCONSIN
GROUP INSURANCE BOARD

DRAFT

Tuesday, August 26, 2008

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

BOARD PRESENT:
Stephen Frankel, Chair
Cindy O'Donnell, Vice-Chair
Esther Olson, Secretary
Robert Baird
Martin Beil
Janis Doleschal
Jennifer Donnelly
Eileen Mallow
David Schmiedicke
Gary Sherman

PARTICIPATING ETF STAFF:
Dave Stella, Secretary
Bob Conlin, Deputy Secretary
Tom Korpady, Administrator, Division of Insurance Services
Bill Kox, Director, Health Benefits and Insurance Plans Bureau
Sharon Walk, Group Insurance Board Liaison

OTHERS PRESENT:
Vickie Baker, Division of Management Services
Paul Basset, Wisconsin Physicians Service
Michelle Baxter, Division of Trust Finance and Employer Services
Katie Beals, Dean Health Plan
Barb Belling, Office of the Commissioner of Insurance
Marcia Blumer, Division of Insurance Services
Jeff Bogardus, Division of Insurance Services
Penny Bound, Dean Health Plan
Andrea Darling, United Health Care
Liz Doss-Anderson, Division of Management Services
Rhonda Dunn, Office of the Secretary
Lisa Ellinger, Division of Insurance Services
Kjirsten Elsner, Minnesota Life Insurance Company
Ralph Epifanio, Anthem Blue Cross Blue Shield
Colleen Evans-Carter, Compcare Blue
Caitlin Frederick, Department of Administration
David Grunke, Wisconsin Physicians Service Insurance Corporation
Tim Gustafson, Deloitte Consulting LLP
Ross Hampton, Wisconsin Education Association Trust
Roni Harper, Division of Insurance Services
Carrie Helms, Network Health Plan
Pamela Henning, Division of Management Services

Sue Hill, Navitus
Steve Hurley, Division of Management Services
Kathy Ikeman, Unity Health Insurance
Dan Joyce, State Engineering Association
Joy Kaiser, Medical Associates Health Plans
Nancy Ketterhagen, Office of the Secretary
Sari King, Division of Retirement Services
Jon Kranz, Office of Internal Audit and Budget
Arlene Larson, Division of Insurance Services
Julie Maendel, Deloitte Consulting LLP
Shelly Mailhiot, United Health Care
Paul Merline, Wisconsin Association of Health Plans
Peg Narloch, Division of Insurance Services
Greg Nelson, Wisconsin Physicians Service Insurance Corporation
Bob Olafson, Minnesota Life Insurance Company
Paul Ostrowski, Office of State Employment Relations
Patrick Pechacek, Deloitte Consulting LLP
Ryan Pelz, Mercy Care
Roxanne Perillo, Humana
Paul Perkins, Group Health Cooperative
Diane Poole, Division of Insurance Services
Clay Rehm, Division of Information Technology
Beth Ritchie, University of Wisconsin System Administration
Deb Roemer, Division of Insurance Services
Peter Roverud, Deloitte Consulting LLP
Paul Rudeen, Minnesota Life Insurance Company
Chris Schmelzer, Minnesota Life Insurance Company
Sam Schmirler, Gundersen Lutheran Health Plan
Julie Schraufnagel, Division of Trust Finance and Employer Services
Shelly Schwartz, Department of Administration
Ron Sebranek, Physicians Plus Insurance Corporation
Mel Sensenbrenner, State Engineers Association
Sonya Sidky, Division of Insurance Services
Joan Steele, Division of Insurance Services
Matt Streiff, Wisconsin Physicians Service Insurance Corporation
Matt Stohr, Director of Legislation, Communications, and Planning
John Verberkmoes, American Federation of Teachers-Wisconsin
John Vincent, Division of Trust Finance and Employer Services
Frankie Winzenried, Anthem Dental Blue
Betty Wittmann, Division of Insurance Services
Nicole Zimm, University of Wisconsin System Administration

Stephen Frankel, Chair, Group Insurance Board (Board), called the meeting to order at 8:34 a.m.

CONSIDERATION OF MINUTES OF JUNE 10, 2008, MEETING

MOTION: Ms. Doleschal moved approval of the minutes of the June 10, 2008, meeting as submitted by the Board Liaison. Ms. Olson seconded the motion, which passed without objection on a voice vote.

MOTION TO CONVENE IN CLOSED SESSION

Mr. Frankel announced that the Board would be meeting in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85(1)(e) to discuss the use of public employee trust funds. Specifically, he stated the Board would discuss 2009 rate setting for the self-insured plans, dental plan changes, service area qualifications, and 2009 tier assignments for the alternate plans. He noted that, upon conclusion of the discussion, the Board would reconvene in open session. Staff from the Department of Employee Trust Funds, the Department of Administration, the Office of the Commissioner of Insurance, the Office of State Employment Relations and Deloitte Consulting were invited to remain during the closed session.

MOTION: Mr. Beil moved to convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1)(e) for the purpose of discussing the use of public employee trust funds. Ms. O'Connell seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Baird, Beil, Doleschal, Donnelly, Frankel, O'Donnell, Olson, Schmiedicke and Sherman.

Members Voting Nay: None

The Board convened in closed session at 8:36 a.m. and reconvened in open session at 10:08 a.m.

Note: Board member Eileen Mallow arrived at 8:40 a.m.

HEALTH INSURANCE PROGRAM

Mr. Korpady announced that the Board took the following action during the closed session:

- The Board approved the actuary's recommendation for the self-insured plans. The state active, Standard and SMP plans will increase by 10%.
- The State Medicare +$1,000,000 Plan will increase by 2%.
- The local active, Standard and SMP plans will increase by 3%.
- The local government standard plan Medicare carve-out will increase by 10%.
- The Board approved the recommended service area qualifications and accepted the methodology and tier placement for 2009.
- The overall rate of increase for the program is 6.6%, with the average weighted increase, including the Standard Plan, being 7%.
- For the local plans, the average weighted increase is 7%.

The Board took a break from 10:09 a.m. to 10:27 a.m.

LIFE INSURANCE PROGRAM ANNUAL REPORT

Paul Rudeen, Minnesota Life Insurance Company (MLIC), presented a summary of the overall highlights for 2007. He shared three reports with the Board: 1) *2007 Policy Year Report; 2) Group Life Insurance Plan Coverages for State Employees and Their Spouses and Dependents;* and 3) *Group Life Insurance Plan Coverages for Local Government Employees and Their Spouses and Dependents.*

He reminded the Board of the four components of the life insurance plan:

1. State employees (active and retired);
2. Spouses and dependents of state employees;
3. Local government employees; and
4. Spouses and dependents of local government employees.

State Group Life Insurance Plan

Mr. Rudeen stated that no changes are being recommended to any of the premium rates under the state portion of the plan. The employee portion experienced a good year and the results were better than target. Although the claims were higher than target in the spouse and dependent portion, the plan is still in a strong financial position.

He noted that state retirees are allowed to convert the value of their post-retirement life insurance into an account that pays toward health insurance premiums or long-term care insurance premiums. During 2007, 120 retirees utilized this option. There are 72,000 insured lives under the plan with over $8.7 billion of insurance in force. The reserve funds under the plan earned 5.8% and the funding of future benefits is at a very strong level.

Based on the analysis of recent experience, MLIC made the following recommendations:

1. No change to the state employee life insurance premium rates in 2009;
2. No change to the stop-loss premium rates in 2009; and
3. No change to the state spouse and dependent premium rates in 2009.

Local Government Group Life Insurance Plan

Under the local portion of the plan, the results were similar to the state plan in that the employee portion had results that were better than target. The spouse and dependent plan had results that were a little worse than target. Mr. Rudeen recommends no premium rate changes to the local portions of the plan.

He noted that in August 2006, the Board approved a reduction to the premium rates for the spouse and dependent coverage from $2.00 per month to $1.75 per month. The rate decrease was implemented on July 1, 2007.

Local retirees also have the option of converting the value of the post-retirement life insurance into an account to pay for health insurance premiums. During 2007, only two retirees utilized

this option. The low number of participating retirees may be due to the fact that very few of the local governments participate in the health insurance plans and they are not offered the long-term care insurance plans.

In 2007, twelve local government employers joined the plan and nineteen increased the number of coverages they had under the plan. There are 686 local employers participating in the life insurance plan. Insurance in force grew by 6% to $9.2 billion and there are over 106,000 insured under the local government plan. The reserve funds earned 5.84% during 2007.

Based on the analysis of recent experience, MLIC made the following recommendations:

1. No change to the local government employee life insurance premium rates in 2009;
2. No change to the stop-loss premium rates in 2009; and
3. No change to the local spouse and dependent premium rates in 2009.

MOTION: Mr. Sherman moved acceptance of the Life Insurance Program Annual Report and approval of the 2009 premium rates as recommended by MLIC. Mr. Baird seconded the motion, which passed without objection on a voice vote.

LONG-TERM DISABILITY INSURANCE (LTDI)

Tim Gustafson of Deloitte Consulting, the Board's actuary, presented the *Long-Term Disability Insurance Plan 2009 Premium Development* report to the Board. He noted that the LTDI program continues to be in an actuarially sound position. Premium contributions have been suspended for a number of years and no change is recommended at this time. Assets in the plan are $325.4 million with liabilities of $135.8 million. The net fund balance is $189.6 million. Paid claims increased from $12.3 million in 2007 to $17.8 million in 2007.

MOTION: Ms. Mallow moved to accept the LTDI 2009 Premium Development report and continuation of the zero premium rate for 2009. Ms. Doleschal seconded the motion, which passed without objection on a voice vote.

2009 OPTIONAL EMPLOYEE-PAY-ALL RATE ADJUSTMENT

EPIC Dental

Mr. Kox reported that EPIC is requesting a 29% premium rate increase for active employees and a 24% premium rate increase for annuitants. The increase consists of 86.5% for increased benefits and 13.5% for overall cost increases. Deloitte Consulting reviewed the EPIC proposal and states that the rate increases are in line with current industry trends.

MOTION: Ms. Olson moved to approve the increase in the Dental and Accidental Death & Dismemberment benefits along with a premium rate increase for EPIC. Mr. Baird seconded the motion, which passed without objection on a voice vote.

DentalBlue

Mr. Kox discussed DentalBlue's proposal for a rate increase on the Preferred Provider Organization (PPO) and Supplemental Dental Plans and no rate increase for the HMO Dental Plan DentalBlue. DentalBlue is also requesting an open enrollment period. The proposed rate increases are:

Dental HMO plan (VDC 186)	0%
Dental PPO plan (VP 864)	8.4%
Supplemental Plan	16.2%

MOTION: Ms. Donnelly moved to accept the DentalBlue proposal for a rate increase on the Dental PPO and Supplemental Plans and no rate increase for the HMO plan. Ms. Mallow seconded the motion, which passed without objection on a voice vote.

MISCELLANEOUS

Mr. Korpady referred the Board to the miscellaneous items in their binders.

ADJOURNMENT

MOTION: Ms. Mallow moved adjournment. Ms. O'Donnell seconded the motion, which passed without objection on a voice vote.

The Board adjourned at 11:02 a.m.

Dated Approved: _____

Signed: _____
Esther Olson, Secretary
Group Insurance Board

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: October 27, 2008

TO: Group Insurance Board

FROM: Robert Weber, Chief Counsel

SUBJECT: Surviving Insured Dependent Rule (Clearinghouse Rule #08-079)

Action Item: The Group Insurance Board is asked to approve the final draft report on the rule, so that it can be submitted to the Legislature for review. No substantial changes were made to the proposed rule previously provided to you. This is the last time this rule-making will come before the Board, unless legislative objections arise.

Description of the rule: This rule-making will repeal and recreate WIS. ADMIN. CODE § ETF 40.01, relating to continued group health insurance coverage of an insured dependent following the death of the insured employee or annuitant.

(a) Summary of existing law: Under the current administrative rule, a dependent must apply for coverage within 90 days in order to continue the dependent's group health insurance as in effect prior to the death. An exception to the 90-day deadline allows the surviving dependent at least 30 days after the Department sends out the standard packet of materials relating to death benefits, including the application for continued health coverage. The grace period assures that a delay in preparing and mailing out a packet will not deprive the surviving insured dependent of the opportunity to continue coverage. If the deadline passes and all previously received premiums have been exhausted, the surviving dependents' health insurance coverage is then terminated. To avoid any unintended loss of coverage, ETF staff often write or call surviving dependents to remind them of the need to apply for the coverage before the deadline expires. ETF staff also spend time responding to dependents who write or call to explain why they failed to timely apply and to belatedly attempt to obtain coverage.

(b) Effect of new rule: This rule-making will address both the customer service and Department work-load issues by reducing or eliminating interruptions in coverage for surviving dependents and reducing staff time spent administering the current application and deadline process. Department staff estimate from anecdotal data that roughly 98% of surviving insured dependents wish to continue their health insurance coverage. This

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

_____ _____
Signature Date

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rule-making provides that health insurance coverage for surviving insured dependents will automatically continue despite the death of the insured employee or annuitant who had family health insurance coverage in effect. The rule envisions that the family coverage in effect at the time of the employee's (or annuitant's) death will be continued, covering the same dependents. The rule spells out who will take over the role of the deceased employee (or annuitant) and be responsible for making all coverage and premium payment decisions.

Generally, only those specific persons actually covered under the family coverage when the insured employee or annuitant died will be covered and no new dependents may be added to the coverage. However, a provision in the rule allows the Group Insurance Board to describe, in the group health insurance contract, certain other persons who may be added to the continuing family coverage. Through contract language, the Board may allow coverage for certain persons who fall into one of the following two broad categories mentioned in the rule:

- Persons previously insured under the Group Insurance Board Health Insurance contract as dependents of the deceased insured employee, who would have been eligible to resume such coverage if the insured employee had lived.
- A child of the deceased insured employee who first became eligible for coverage under the group insurance board health insurance contract after the death of the insured employee.

The rule also provides that the group health insurance contract will control the duration of coverage for a surviving insured dependent other than a spouse. Under the rule, a surviving spouse's coverage is for life, unless sooner terminated voluntarily or by failing to pay premiums. Other survivors may outgrow dependent status, or no longer qualify by, for example, ceasing to be a full-time student or by recovering from disability.

Payment for the continued insurance coverage is automatically provided in the rule by applying, in order: (1) any advance premium payments already in hand; (2) remaining sick leave conversion credits; (3) WRS annuity deduction; and, (4) direct payments made by the responsible surviving insured dependent. A special provision is included in the rule to protect surviving insured dependents who want to take advantage of the opportunity to "escrow" the deceased employee's (or annuitant's) accumulated sick leave conversion credits because other comparable health insurance is available to them. The rule treats this as a temporary suspension of the continued coverage, not as a voluntary termination that would bar any future coverage under this rule.

Deloitte.

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October 15, 2008

Ms. Betty Wittmann
Manager, Optional Plans & Audits
Division of Insurance Services
Department of Employee Trust Funds
801 West Badger Road
Madison, WI 53702

Re: 2009 Gateway Ventures, Inc. Pre-Paid Legal Insurance Coverage – Proposal for Optional Benefits

Dear Betty:

As requested by the State of Wisconsin Department of Employee Trust Funds we have reviewed the information submitted by Gateway Ventures, Inc (Gateway Ventures) to offer pre-paid legal insurance coverage through Pre-Paid Legal Casualty, Inc as an optional employee benefit. This plan would be a voluntary, payroll-deduction pre-paid legal services benefit for active state and university employees and their dependents.

Gateway Ventures is proposing offering optional pre-paid legal insurance at a rate of $14.75 per month without the legal shield and $15.75 per month with the legal shield. Based on our analysis we believe the proposed optional pre-paid legal insurance benefit does not fall within the Group Insurance Board's guidelines. Specifically, the anticipated loss ratio for the plan of 42% does not meet the 75% minimum requirement for optional group insurance plans. In addition, we view Gateway Ventures' 42% loss ratio as inclusive of the full value of the benefits offered when compared to other employee benefit plans, even considering the capitated payment structure and other characteristics of the plan.

This memo summarizes our analysis of the proposed optional pre-paid legal insurance benefit. We received the Gateway Ventures, Inc. Optional Group Insurance Plan Application (the application), which included the following supporting documentation:

- Current group policy listing
- Sample agreement for insurance coverage
- Sample policy certificate and applicable addendums
- Annual Company Report
- Yellow Blank 2007 Annual Statement
- Other various supplemental information

Summary of Gateway Ventures Proposal

The following summarizes Gateway Venture's proposed optional pre-paid legal insurance benefit and the justification for a lower than required minimum loss ratio.

- **Benefits –** The plan offers legal benefits in the following areas. Please note, these benefits are subject to exclusions as outlined in the application and policy certificate.
    - Telephone consultations and limited legal research
    - Phone calls and letters on policyholder's behalf
    - Contract and document review
    - Mortgage document assistance
    - Representation in an uncontested legal separation, divorce, adoption, and name change
    - Preparation of health care power of attorney, directive to physician or living will and standard last will and testament
    - Motor vehicle related benefits
    - Trial defense benefits
    - IRS audit protection service
    - In-office consultation
    - Discounts for other legal work
    - Legal Shield Addendum
        - This addendum provides for 24 hour emergency access to the provider attorney for situations involving detainment of a covered individual by a law enforcement agency for questioning, involvement in an accident resulting in bodily harm, or being served with a warrant.

- **Premium Rate Development** – The proposed premium rate structure is $14.75 for the legal plan without the Legal Shield Addendum and $15.75 for the legal plan with the Legal Shield Addendum. These rates were developed based on utilization and provider payment data from the early 1980's. According to the proposal, the current premium rates target 33-45% of premium paid as claims. The premium rates are not expected to increase in the near future.

- **Loss Ratio Development –** As noted above, the plan targets premiums that produce a loss ratio between 33% and 45%. In section 4.c. of the application, Gateway Ventures notes that the loss ratio for the proposed plan is 42%. However, a summary of the numerical development of this loss ratio was not provided. Given the loss ratio does not meet the 75% minimum loss ratio requirement set forth by the Group Insurance Board, Gateway Ventures provides several reasons why the 42% loss ratio is not inclusive of the true paid claims amount. These justifications include:

- **Capitated Rates to Providers –** The claim payment structure of the legal plan is to pay providers on a capitated rate basis. Gateway Ventures purports that the capitated rates do not directly correlate with actual utilization and the value of the services provided. As a result, a loss ratio based only on the amount of capitated fees paid to providers understates the loss ratio according to Gateway Ventures. Gateway Ventures did not provide any specific figures or support to quantify the assertion that capitated rates do not directly correlate with actual utilization and the value of the plan.

- **American Academy of Actuaries (AAA) Loss Ratio Work Group Paper –** Gateway Ventures cites an AAA Loss Ratio Work Group Paper published in 1998 outlining the limitations and pitfalls of using loss ratios as an experience measure. This paper notes that the impact of fixed expenses (computers, employee costs, overhead, rent, etc.) has a diminished effect on the loss ratio as the premium base grows. The expenses of the legal plan make up a greater than average proportion of premium given the low premiums for the plan. Thus, a decreased loss ratio measure as a minimum standard could be justified. This paper also notes that there is not a clear definition of the items to be included as a claim when calculating a loss ratio. Gateway Ventures believes they provide additional services to providers that are ultimately benefits to insureds, such as computer services which reduce administrative work, decreased collection costs or write offs, decreasing advertising costs. However, as discussed further below, in other types of coverages found in the employee benefits industry, these types of ancillary or indirect services are not included in the loss ratio calculation or otherwise explicitly factored into the evaluation of the reasonableness of the benefits provided in relation to premiums charged.

Deloitte Consulting Analysis

Our analysis included reviewing the information received within the application, specifically the reasonableness of the anticipated 42% loss ratio in relation to the Group Insurance Board's 75% minimum loss ratio guideline.

- **Benefits and Premium Rate Development –** We did not evaluate the quality or structure of the benefits provided within the pre-paid legal plan as this falls outside the scope of our area of expertise. Additionally, Gateway Ventures did not provide numerical documentation of the development of the proposed premium rates to be able to assess their reasonableness.

- **Loss Ratio Development –** As noted above Gateway Ventures states an anticipated loss ratio for this plan is 42%. Although we were not provided with documentation of the development of this loss ratio, we did consider the earned premiums and incurred claims as presented in Pre-Paid Legal Casualty, Inc.'s 2007 annual statement. Based on the earned premium and incurred claims within this annual statement, we calculate a historical loss ratio of approximately 31%. This loss ratio does not meet the Group Insurance Boards 75% minimum loss ratio requirement.

We also noted from the annual statement that the Company incurred commission and brokerage expenses of approximately 27.5% of the 2007 premiums, and realized approximately 18.9% pre-tax profits on its overall book of business. These commission expenses and profit margins are significantly greater than what would be expected for an employee benefits plan based on industry norms.

- **Consideration of Capitated Rates in the Loss Ratio –** Gateway Ventures suggests that because the 42% anticipated loss ratio is only based on capitated fees paid to providers, the loss ratio is understated. This alleged understatement stems from Gateway Ventures' viewpoint that capitated rates do not directly reflect both the utilization of the plan and the value of the services provided. However, our viewpoint is that providers will only enter into capitated arrangements if the fees they will receive are an accurate fair market value of the services they are being asked to provide. As a result, we believe the total capitated fees paid to providers is an accurate representation of the actual utilization and value of the plan and thus a loss ratio based on these fees does not necessarily understate the value of the plan.

  In addition, we note that the AAA Loss Ratio Work Group paper states there are items such as cost containment, care management and network development which are not considered a part of the claims paid amount when calculating a loss ratio that should be considered a part of the value of the plan. However, we do not believe Gateway Ventures pre-paid legal plan has these types of additional items that should be considered accretive to the loss ratio. First, all claims risk is transferred to providers because of the capitated rate structure, so Gateway Ventures is not incurring any separate cost containment or care management expenses. Second, Gateway Venture's viewpoint that the assessment of the value of the benefits should reflect the legal services costs on a non-discounted basis would be analogous to HMOs being able to count provider billed charges, as opposed to negotiated discounted charges or capitated rates, in their loss ratio calculations, which is not in line with industry practices.

- **Review of AAA Loss Ratio Work Group Paper** – We reviewed this work group paper focusing on the areas cited by Gateway Ventures relevant to the determination of the true loss ratio of the plan. Given the relatively low premiums for this coverage, the NAIC guidance on minimum loss ratio requirements does suggest the potential reasonableness of a reduced minimum loss ratio requirement, although the 42% anticipated loss ratio would not meet even a reduced requirement. We also considered the additional services provided by Pre-Paid Legal Casualty, Inc to providers, such as reduced administrative work and reduced collection and advertising costs. We believe these costs and savings are accurately reflected within the capitated rate paid to providers and therefore should not be considered as additional benefits to insureds compared to how other employee benefit plans are evaluated. Overall, our assessment is that the AAA paper does not provide support to justify a 42% loss ratio reasonableness standard for this coverage, nor did Gateway Ventures provide sufficient numerical support to justify the consideration of a reduced minimum loss ratio requirement. Therefore, our conclusion is that Gateway Ventures has not justified a higher retention rate than is generally accepted by the Group Insurance Board.

Summary

Based on our analysis from an actuarial perspective, the proposal to offer optional group pre-paid legal insurance does not appear to be in line with the Group Insurance Board's guidelines nor does it warrant a lower loss ratio consideration. We reached this conclusion after consideration of the application materials submitted by Gateway Ventures, primarily focusing on the anticipated loss ratio of the plan in light of the Group Insurance Board's minimum loss ratio requirement.

Sincerely,

Timothy D. Gustafson

Timothy D. Gustafson, FSA, MAAA

cc: Timothy FitzPatrick, Dawn Gross, Nathan Berggoetz

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: October 29, 2008

TO: Group Insurance Board

FROM: Betty Wittmann, Manager
Optional Insurance Plans and Audits

SUBJECT: Gateway Ventures, Inc, Pre-Paid Legal Services Proposal

Recommendation

Staff recommends that the Board not approve Gateway Ventures, Inc.'s request to offer Pre-Paid Legal Services through Pre-Paid Legal Casualty, Inc. (PPLC) for payroll deduction as it does not meet the Board's loss ratio requirements.

Background

Under authority granted to the Group Insurance Board (Board) by Wis. Stats. § 40.03(6)(b) and pursuant to Wis. Stats. § 20.921 (1)(a) 3, and Wis. Admin. Code § ETF10.20, the Board may authorize optional group insurance for payroll deduction where employees pay the entire premiums for such plans. Such proposals are reviewed under the Board's Guidelines for Optional Group Insurance Plans Seeking Group Insurance Board Approval for Payroll Deduction Authorization. An analysis by Deloitte, the Board's Consulting Actuary, is attached.

PPLC and its parent company, Pre-Paid Legal Services (PPL), are domiciled in the state of Oklahoma. In 1988, PPLC was licensed as a property and casualty insurer in the state of Wisconsin under Chapter 618 of the Wisconsin Statutes and is regulated by the commissioner of insurance according to Wis. Admin. Code § Ins 22.01(1).

Gateway Ventures Inc., an Independent Marketing Associate of PPL will market the PPLC policy and utilizing licensed insurance agents to sell policies. The PPLC plan indicates that for a membership fee of $14.75 per month, it would make available certain preventative legal services, motor vehicle defense services, trial defense services, will preparation services, IRS audit services and a 25% discount off other legal services. PPLC also offers a legal shield rider that provides 24-hour access to a toll-free number for attorney assistance if the member is arrested or detained. The cost for the rider is an additional $1.00 per month. The proposed premium rates would be guaranteed for three years.

Discussion

Staff is recommending against approval of the proposal due to its failure to meet the Board's loss ratio requirement. Specifically, the Board requires that at least 75% of the total premium collected be used to pay provider's claims under the policy. The Board developed this requirement to ensure that proposed plans offer good value to our participants, while retaining a

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

_____ _____
Signature Date

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reasonable portion of the premium to cover administration cost and profit. A loss ratio below 75% will not normally be eligible for consideration unless the higher retention ratio is justified.

Gateway has asked for an exception to the 75% loss ratio and proposes a 42% loss ratio. In their view, the plan offers value in excess of the capitated payments (claims). In addition, Gateway cites the Loss Ratio Work Group Paper of the American Academy of Actuaries (AAA). However, Deloitte indicates the capitated rate structure is an accurate, fair-market value of the services, and an accurate representation of the value of the plan. Further Deloitte reviewed the findings of the AAA Loss Ratio Work Group Paper and does not believe it supports a 42% loss ratio.

Deloitte's loss ratio development analysis, beginning on page 3 of the attached memo, calculated an actual historical loss ratio of 31% based on PPLC's earned premiums and incurred claims (i.e. capitated payments) as presented in the 2007 annual statement (Exhibit G). As a result a very high portion of the premiums are retained for profit, agent commissions, and administrative expenses. In comparison with other employee benefit plans, Deloitte determined these commission expenses and profit margins to be significantly greater than industry norms.

Concerning the benefits of the plan, it appears they are geared towards providing initial consultations with an attorney, document review (under 10 pages), and basic will preparation service. The will preparation is based on a questionnaire (no meeting) and does not include execution of the will or storage and if the member would like to have it executed or stored they would need to utilize the 25% discount. The representation offered under the membership fee applies to non-felony and uncontested matters such as adoption (no guardianship proceedings), legal separation, or divorce where net marital assets are under $100,000 and/or involve division of retirement assets.

Staff reviewed the benefits provisions, exclusions, and limitations in the membership and was not able to determine the value of these benefits since no claims or quantifiable information was provided. This will also make annual reporting a challenge, as PPLC has stated that it can only report enrollment, provider inquiries, and financial information. Since this product is offered to employees on a capitated basis and the services are legal in nature, utilization statistics are not available.

Conclusion

Based on the review by staff and the Board's actuary, we do not recommend accepting the Gateway Ventures, Inc. pre-paid legal services proposal. While the policy provides some access to legal services, the exclusions and limitations are extensive. In addition, the premium is used to provide a substantial agent commission and profit and does not satisfy the Board's 75% loss ratio or any reasonable extension of it.

Staff will be available at the meeting to answer any questions you may have regarding this matter.

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: October 28, 2008

TO: Group Insurance Board

FROM: Jon Kranz, Director
Office of Internal Audit and Budget

SUBJECT: FY 2009-11 Department Biennial Budget Update

Attached is a summary of the fiscal year (FY) 2009-11 biennial budget request submitted by the Department on September 26, 2008. The period covered by the budget is July 1, 2009-June 30, 2011.

Included in the FY 2009-11 biennial budget request are the following three Department initiatives:

1. Continuation of Critical Customer Services
2. Group Insurance Program Efficiencies
3. Headquarter Facility Planning and Design

The Department has also submitted a capital budget request to build or purchase a new headquarters facility. Item three, above, requests the associated funding for the planning and design phase of this project.

The attached document provides background information regarding the factors driving this budget request, along with a summary of each initiative. Of interest to Group Insurance Board (GIB) members may be the four statutory changes associated with the administration of the Group Insurance Program. These items are as follows:

1. **Flexibility to allow the GIB to modify the Uniform Benefits package to allow for the inclusion of wellness incentives without having to reduce other benefits.** Under current law, any additions to Uniform Benefits approved by the GIB must be offset by an equivalent reduction in benefits. The proposed statutory change would more easily allow for the implementation of wellness incentives.

2. **Increased authority for the GIB to contract for data collection and analysis services.** Current law allows for the GIB to contract for data collection and analysis but does not provide specific authority to obtain additional specialized resources that would be required to use this information to implement initiatives related to programs such as wellness and disease management. The proposed statutory change would provide increased authority to the GIB to obtain the necessary services required to implement these types of initiatives.

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

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3. The Chapter 20 appropriation that provides partial funding for these projects would also be modified accordingly.

4. **Removal of the requirement for state agencies to obtain GIB approval for optional employee-pay-all benefits.** Current law requires GIB approval for any optional group insurance plan for state employees that will be paid via payroll deduction. The proposed statutory change would eliminate this requirement.

5. **Flexibility to allow the GIB to determine long-term care benefits.** Current law requires that the GIB offer any long-term care plan that is approved by the Office of the Commissioner of Insurance and meets the standards established by the GIB. The proposed change would allow the GIB to further limit participation.

Please contact me at (608) 267-0908 should you desire any additional information.

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Summary of the Employee Trust Funds FY 2009-2011 Biennial Budget Request

This is a summary of the fiscal year (FY) 2009-2011 biennial budget request for the Department of Employee Trust Funds (Department). The period covered by this request is July 1, 2009 – June 30, 2011.

The Department currently has relatively low administrative costs but, in turn, we offer Wisconsin Retirement System (WRS) participants fewer services and longer wait times due to a lack of resources. The Department has taken many steps to improve services through the use of technology and administrative process redesign. However, those efforts alone will not allow the Board and the Department to carry out their fiduciary responsibilities to participants. That is especially true considering the fact the "eligible to retire" population alone is expected to increase more than 18% from FY 2007 to FY 2011. Looking further into the future, our actuary projects that our annuitant population will more than double in 30 years. It isn't a question of if our workload will increase; rather it is a question of how quickly it will increase. The current budgetary system does not allow us to plan for, or be ready for, this workload issue when it occurs.

More must be done to address our current and future challenges and to ensure we are able to provide contractually-defined benefits to WRS participants. Our budget request contains mechanisms and solutions to meet these challenges.

What is driving this request?

1) Increasing workload associated with the retirement of the baby boom generation.

a. Eligible to retire population expected to increase 18.1% from FY 2007 to FY 2011.

b. New annuities expected to increase 19.9% from FY 2007 to FY 2011.

c. The annuitant population will increase to more than 165,000 from the current level of approximately 145,000 from FY 2007 to FY 2011.

2) The current model used to provide the agency with expenditure and position authority is inflexible and hinders the ability to create and implement long-term strategies to address an increasing workload.

a. The current model requires that the Department predict precise workload levels one to two years in advance of the actual activity.

b. The Department must "compete" with other agencies for resources, even though the Department is 100% funded from the Public Employee Trust Fund and not state tax funds.

c. Should actual workload during the biennium increase significantly more than predicted, the only option is to request emergency funding or further reduce service levels.

d. The current "annual" appropriation model makes it difficult, if not impossible, to effectively create and implement long-term strategies to address the workload issues associated with the retirement of the "baby boom" generation. Under the current system, funding commitments are limited to no more than two years.

3) The current process for obtaining position and expenditure authority is not a "best practice" in terms of Trust governance as identified in a governance study performed by Ennis Knupp and Associates (presented at the June 2008 ETF Board Meeting). In addition, based on the Ennis Knupp report, staff recommends that statutory ambiguities regarding the Board's and Department's authority to contract for goods and services be clarified.

4) The desire to increase service levels to participants to at least the median of peer public pension systems.

a. Current service levels are well below the median of our peers according to a recent Cost Effective Measurement (CEM) Benchmarking report for FY 2007.

1. CEM is an independent research firm that, on a global basis, performs benchmarking studies for pension administration and pension investment performance. The peer system used by CEM for the WRS was independently selected by CEM based on comparable systems.

2. In the FY 2007 study, the WRS service score was 60 compared to the peer system median of 73 (the higher the score, the higher the service level).

3. In the FY 2007 study, the annual WRS cost per participant (active and annuitant) was $53 compared to the peer median of $65.

5) Participants are increasingly demanding more information and higher levels of service when making important decisions about retirement and other fringe benefits.

How does the biennial budget request address these needs?

The Department's budget request consists of seven elements:

1) Request a change from the current annual appropriation model to a continuing appropriation.

a. Annual expenditure authority amounts would be based on the peer system median amount per participant (CEM information will be used initially with adjustments to account for the benefit programs not included in the CEM analysis).

b. Unused expenditure authority in a given fiscal year would carry forward to the next fiscal year (builds a reserve to accommodate workload spikes).

c. Board concurrence would need to be obtained if workload metrics indicate that it is necessary for the Department to exceed the peer median amount per participant in a given fiscal year.

d. Expenditure authority would be $35,952,600 for FY 2010 and $37,981,500 for FY 2011 based on the most recent CEM data. For the current fiscal year (FY 2009) the Department's budget authority is $25,011,900.

e. The expenditure authority requested above is equivalent to 4.4 basis points of the WRS assets or 0.71% of annual benefit payments.

2) Request the creation of a passive review process to create or delete position authority.

a. The Department would request the creation or deletion of positions based on actual workload metrics.

b. The Department's position level would not exceed the peer system median ratio of participants to full-time equivalent (FTE) positions without Board approval.

c. For FY 2007, the WRS ratio of participants (active and annuitant) per FTE was 2,495/1 compared to the peer median of 1,790/1.

d. Based on internal Department projections and actuarial data, the number of new positions required to address some of the workload issues will be 25.0 FTE for FY 2010 and 24.0 FTE for FY 2011.

e. The peer system median position limit (adjusted to account for the programs not included in the CEM analysis) would be 283.39 FTE or 62.59 more FTE positions than currently authorized for the current FY 2009 year.

3) Request statutory changes to eliminate current ambiguities regarding the Board's independent ability to contract for necessary goods and services.

4) Request changes to require annual reporting by the Department regarding the use of funds, positions, and contracting authority to the Joint Committee on Finance and the Department of Administration to enhance accountability and transparency.

5) Request appropriate funding levels for the GPR annuity supplements for certain pre-1974 retirees – this will be a decrease from current funding levels.

6) Request a capital budget associated with obtaining a new headquarters facility.

7) Request statutory changes to improve efficiencies and effectiveness of the insurance programs.

a. Statutory change to clarify that GIB may modify benefits to allow for the incorporation of wellness incentives (s. 40.03 (6) (c)).

b. Statutory change to broaden the authority of GIB to hire for data collection and analysis services (s. 40.03 (6) (j)).

c. Statutory change to eliminate GIB approval of optional insurances (s. 20.921 (1) (a) (3)).

d. Statutory change to provide additional flexibility to determine long-term care insurance options (s. 40.55).

Summary of the most recent three ETF biennial budget requests

Fiscal Biennium	ETF Request FTE	ETF Request New Funding	Enacted Budget FTE	Enacted Budget New Funding	Enacted/Requested FTE	Enacted/Requested New Funding
FY 2007-2009	63.00	$ 14,748,200	24.50	$ 10,997,700	38.9%	74.6%
FY 2005-2007	4.50	$ 1,199,100	1.75	$ 1,034,500	38.9%	86.3%
FY 2003-2005	27.80	$ 7,097,700	10.00	$ 4,179,100	36.0%	58.9%
	95.30	**$ 23,045,000**	**36.25**	**$ 16,211,300**	**38.0%**	**70.3%**

New funding amount is the biennial total (on-going and one-time) less standard budget.

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CORRESPONDENCE MEMORANDUM

DATE: October 20, 2008

TO: Group Insurance Board

FROM: Arlene Larson, Manager, Self-Insured Health Plans

SUBJECT: 2009 Local Annuitant Health Plan Rates 2009

This memo is for the Board's information only. No action is required.

Attached are the rates for the Local Annuitant Health Plan (LAHP), effective January 1, 2009. LAHP is a fully insured plan provided by the Standard Plan administrator, WPS Health Insurance, pursuant to Wis. Stat. § 40.51(10). It is available on an individual basis to local government annuitants. This year's increase for the Medicare supplement and the under-age-65 Preferred Provider Plan (PPP) is 6.59%. Deloitte Consulting reviewed the renewal and determined that it was reasonable.

LAHP was authorized in the statutes on July 1, 1988, as a health insurance program to offer individual coverage for those retiring local government employees and their dependents who are not offered a group plan by their municipal employer. The program is voluntary for retirees of employers who participate in the Wisconsin Retirement System. The rates are provided annually in November, following the establishment of Medicare deductibles for the following year.

Because many municipalities offer coverage for their annuitants, LAHP insures a very small population and is subject to adverse selection. Enrollment has been stable since 2006. Currently there are 298 subscribers. In 2007 there were 304 subscribers, in 2006 there were 303 and in 2005, 349. As of June 2008, there were 285 enrolled in the Medicare Supplement, of whom 219 were aged 75 and over. Currently, 13 subscribers are enrolled in the PPP.

Note: WPS is adding a provision to comply with Michelle's Law, concerning coverage of certain full-time students, as required by Wis. Stat. § 632.895 (15), which is effective January 1, 2009. The booklet insert is attached.

Attachments

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

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LOCAL ANNUITANT HEALTH PROGRAM (LAHP)
RETIREES MONTHLY HEALTH INSURANCE PREMIUMS

EFFECTIVE 01/2008

		PPP		Medicare Supplement*		
Annuity Plan/Coverage Code		15	16	17	18	19
HICS Coverage Code		01	02	05	07	06
Suffix	Coverage	Single	Family	Single	Family-2	Family-1
A6	PPP - Under Age 65 - No Med	883.40	1,761.80			
B1	PPP - Under Age 65 - With Med	618.90				
B2	PPP - Under Age 65 - Both with Med		1,235.60			
B3	PPP - Under Age 65 - One with Med, Other Not		1,499.80			
B4	PPP - Under Age 65 - Two with Med, 3rd Not		1,769.00			
D1	Med Sup - Age 65-67			133.80	265.10	1,014.50
D2	Med Sup - Age 68-69			148.80	295.00	1,029.50
D3	Med Sup - Age 70-74			183.20	364.00	1,064.00
D4	Med Sup - Age 75 and Over			207.90	413.30	1,088.60

EFFECTIVE 1/2009

PPP		Medicare Supplement*		
15	16	17	18	19
01	02	05	07	06
Single	Family	Single	Family-2	Family-1
941.60	1,877.90			
659.70				
	1,317.00			
	1,598.60			
	1,885.60			
		142.60	282.60	1,081.40
		158.60	314.40	1,097.30
		195.30	388.00	1,134.10
		221.60	440.50	1,160.30

Includes a $2.50 administrative fee.
*Rate determined by subscriber's age as of the 1st of the calendar year

PPP - Preferred Provider Plan for those under the age of 65, network identical to State Standard PPP, $250 individual deductible, capped at 3 for the family, in-network coinsurance of 80%/20% to $2,500/$5,000, out-of-network coinsurance of 60%/40% to $2,500/$5,000, amounts are combined so maximum coinsurance out-of-pocket will be $2,500/$5,000 in total

Medicare Supplement - For those over 65 an age-rating premium rate structure

WPS HEALTH INSURANCE

Important information regarding your WPS Policy

As you may have heard, the State of Wisconsin enacted a law regarding full-time dependent student coverage. Wisconsin Statute section 632.895(15) requires insurers to continue providing coverage to dependent students as if they were a full-time student, if they cease to be a full-time student due to a medically necessary leave of absence.

Please have your employees review the Amended Benefit Endorsement they will be receiving on or after your renewal date, describing the new benefit and its limitations.

You are not required to do anything at this time. This change will be made automatically effective upon your renewal.

If your group is affected by a collective bargaining agreement you may request that we delay the effective date of this benefit until the date the agreement is extended, modified or renewed; whichever is earlier. Please contact your Sales Representative or Agency Representative prior to your renewal date if you wish to delay the effective date as stated above.

WPS is committed in providing you with the health plan that best meets your needs. If you have questions about these changes, please contact your WPS Sales Representative or Agency Representative.

Thank You.

7/1/08

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CORRESPONDENCE MEMORANDUM

DATE: October 21, 2008

TO: Group Insurance Board

FROM: Betty Wittmann, Manager
Optional Insurance Plans & Audits

SUBJECT: Status Update –Optional Vision and Accidental Death & Dismemberment (AD&D) Programs

This memo is informational only. No Board action is necessary.
This memo provides an update on the status of the optional vision care insurance provided by Spectera (OptumHealth Vision) and the AD&D insurance provided by The Hartford Life Insurance Company.

Background

Under authority granted to the Group Insurance Board (Board) by Wis. Stats. § 40.03 (6) (b) and pursuant to Wis. Stats. § 20.921 (1)(a) 3 and Wis. Admin. Code § ETF 10.20, the Board is responsible for approving optional group insurance plans to be offered via payroll deduction. In 2003 the Board approved the Spectera vision plan that is currently available to active state and university employees as well as eligible retirees. In 1989 the Board approved the AD&D plan through CNA Financial Corporation, which was acquired by The Hartford Life Insurance Company in 2003.

Discussion - Optional Vision Program

In 2001, UnitedHealthcare Group (UHC) acquired Spectera and in late 2006 the merged companies formed UnitedHealthcare Specialty Benefits, marketing themselves to members as OptumHealth Vision. The merger has had a positive affect on the relationship between Spectera and the State by making key individuals within UHC more accessible. This has improved communication and helped to resolve the administrative and enrollment issues that accumulated over the last five years. In addition, UHC's information technology systems and resources have provided a more accurate picture of enrollment and claims data that is reported to the department annually.

Spectera/OptumHealth Vision is offering an open enrollment opportunity for state and university employees, as well as eligible retired state employees. Coverage is effective January 1, 2009. The open enrollment period will run until November 14, 2008. It should also be noted that annuitants that are enrolled in the vision program in 2008 would no longer have to re-enroll each year to maintain continuous coverage.

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

_____ _____
Signature Date

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The following chart highlights the utilization information gathered for the Spectera Vision program.

Spectera (OptumHealth) Vision Insurance Program		
Utilization Statistics 2007	**Actives**	**Annuitants**
Enrolled Participants	8626	230
Enrollment % change from 2004	8% Increase	50% Decrease
Premium Income	$905,394.91	$45,969.80
Amount of Claims	$692,994.57	$39,531.09
Loss Ratio (includes admin cost)	88% combined (down from 103% in 2006)	

Discussion - Optional Accidental Death & Dismemberment (AD&D) Program

Currently, The Hartford offers AD&D benefits to twenty-nine state agencies with approximately 5,800 active state employees enrolled in the plan. The Department of Corrections, the Department of Transportation and the Department of Natural Resources together make up 66% of the total premium in the AD&D plan.

AD&D tends to be a volatile plan with low premiums and fluctuating claims, which holds with the State of Wisconsin program. Previously, the Board has considered its 75% loss ratio requirement and anticipates these volatile plans will meet the requirement over longer periods of time (15 or more years). The Hartford is comparing the existing CNA plan, which has been in effect since 2001, with a more up to date AD&D plan from their portfolio. The Hartford may wish to discuss a replacement policy with employers and ETF.

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CORRESPONDENCE MEMORANDUM

DATE: October 29, 2008

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson, Quality Assurance Services Bureau
Vickie Baker, Ombudsperson, Quality Assurance Services Bureau
Christina Keeley, Ombudsperson, Quality Assurance Services Bureau
Sharon Walk, Executive Staff Assistant, Quality Assurance Services Bureau

SUBJECT: Correspondence and Complaint Summary

This summary is provided for informational purposes only. No Board action is necessary.
The summary contains a listing of issues raised by participants relating to insurance benefits under the authority of the Group Insurance Board (GIB). The tables below include a summary of the following for the period of August 1, 2008, through September 30, 2008:

(1) correspondence received by the Department addressed to the Secretary or the GIB;

(2) the number of requests for information and assistance made to the ombudspersons in the Quality Assurance Services Bureau (QASB).

QASB staff will be available at the Board meeting to address any questions you have regarding this report.

Correspondence:

	Number
Health Insurance	
• Member would like the Board to offer a "two-person" premium rate in addition to single and family coverage.	**1**
• Concern about the cost difference for a medical sleep apnea machine purchased from Meriter Home Health/Physicians Plus versus the purchase of the same unit through an Internet vendor.	**1**
• Health insurance options available to members in western Wisconsin	**1**
Pharmacy Benefits	
• **N/A**	**0**
Disability Programs	
• **N/A**	**0**
TOTAL	**3**

Contacts to Ombudspersons:
From August 1, 2008, through September 30, 2008, 173 members contacted the ombudspersons for assistance with benefit issues. The majority of these contacts involved health insurance and pharmacy benefits, which includes Medicare Part D.

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

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Signature Date

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Recurring issues identified by staff include:

- We received a significant number of contacts related to incorrect administration of Uniform Benefits, claims processing problems or delays, and provider network issues – primarily for Anthem, Humana (including Humana Private Fee For Service (PFFS)), and Wisconsin Physician Service (WPS).
- Nine members contacted the Department after their claims for the shingles vaccine were denied by WPS-Medicare Plus $1 Million or needed assistance to facilitate payment by a health maintenance organization or the Humana Medicare Advantage PFFS Plan.
- Several contacts related to getting assistance with coverage of self-administered injectable or intramuscular products, typically where there is disagreement about whether the plan or the PBM is responsible for coverage.
- We received a relatively high number of policy-related questions. These questions typically regard benefit coverage, eligibility for health insurance or questions/concerns about upcoming changes in health insurance coverage.
- Many members contacted ETF about Medicare coordination of benefits and Medicare eligibility/enrollment problems.

The following tables summarize the method of contact and program areas involved compared with the same period in 2007.

Total Contacts	**Aug-Sept 2008**	**Aug-Sept 2007**
August	81	83
September	92	71
Total	173	154

Method of Contact	**Jan-Sept 2008**	**Jan-Sept 2007**
Telephone	792	N/A
E-mail/Contact Us Internet Page	167	N/A
US Mail	51	N/A
Walk-In	18	N/A

Number of Contacts by Program	**Jan-Sept 2008**	**Jan-Sept 2007**
Health Insurance-HMO's	549	370
Health Insurance-Self Funded	200	195
Pharmacy Benefits	168	92
Non WRS Programs (DentalBlue)	32	25
Disability/Income Continuation Insurance	20	18
All Other Program Types* (Life Insurance, ERA, EPIC, Spectera, WRS/ASLCC and WDC)	59	37

*It is not common to receive a large number of complaints regarding these programs. The availability of ombudsperson assistance in this area is not widely known and most of these programs are not under contract with ETF; rather, they are benefits that the Board simply approves to be offered through payroll deduction.

Key:

- *ASLCC: Accumulated Sick Leave Conversion Credit*
- *ERA: Employee Reimbursement Accounts. Optional pre-tax savings account for medical expenses and dependent care.*
- *EPIC: Optional supplemental benefit plan that provides coverage for dental, excess medical and accidental death and dismemberment.*
- *Spectera: Optional vision benefit*
- *WDC: Wisconsin Deferred Compensation*
- *WRS: Wisconsin Retirement System*

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CORRESPONDENCE MEMORANDUM

DATE: October 1, 2008

TO: Group Insurance Board

FROM: Sharon Walk
Appeals Coordinator

SUBJECT: Pending Appeals

PENDING APPEALS BY BOARD						
As of:	ETF	GIB	WR	TR	DC	TOTAL
09/01/08	**16**	**8**	**9**	**0**	**0**	**33**
New Appeals (+)	+1	0	0	0	0	+1
Final Decisions (-)	0	0	0	0	0	0
Appeals Withdrawn (-)	-4	-1	-1	0	0	-6
10/01/08	**13**	**7**	**8**	**0**	**0**	**28**
+/-	-3	-1	-1	0	0	-5

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

_____ _____
Signature Date

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