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CORRESPONDENCE MEMORANDUM

DATE: October 23, 2009

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson
Vickie Baker, Ombudsperson
Christina Keeley, Ombudsperson

SUBJECT: Quarterly Ombudsperson Complaint Report

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

This summary contains information and statistics about the complaints or inquires raised by members, their families, employers and external advocacy organizations relating to benefits that fall under the authority of the Group Insurance Board (GIB).

The Department's Ombudsperson staff attempts to resolve member issues, provide education and outreach to Wisconsin Retirement System (WRS) members, and work to ensure that all WRS members have access to timely, accurate, and thorough information regarding benefits administered by the Department. We work closely with the health plans and third-party administrators (such as WPS, Navitus, Aetna, etc.) to ensure plans provide appropriate benefit administration and quality services to members.

During this reporting period of July – September 2009, we received 333 contacts from members or their representatives regarding benefits. One hundred and four of these contacts were education or outreach in nature. The remaining 229 are summarized below.

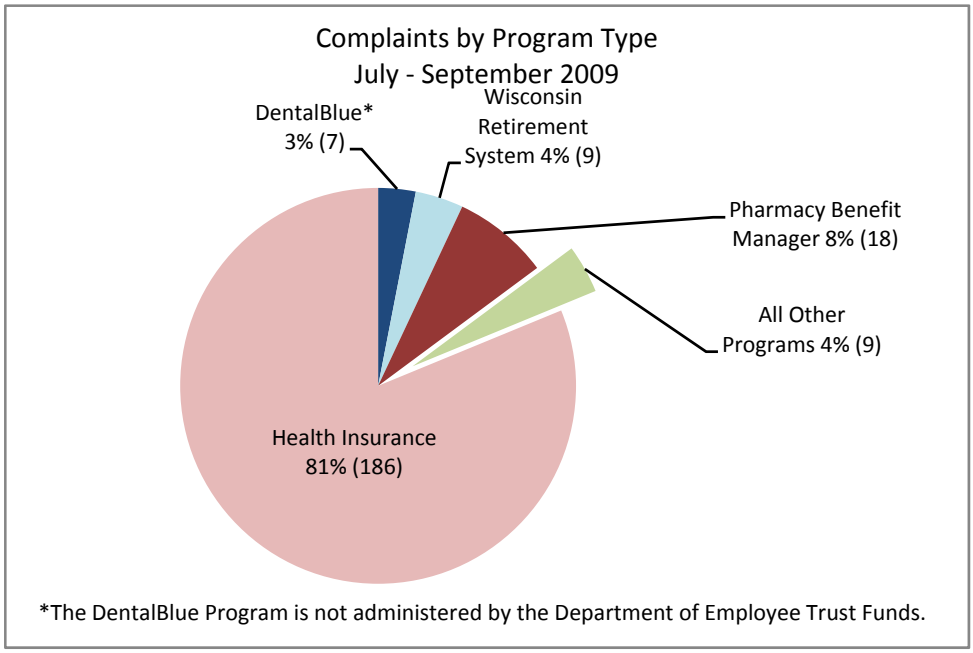
Contacts by Program Type

Of the 229 complaints (see chart on next page), health insurance continues to be the program that generates the majority of contacts to the Ombudspersons, with 186 complaints. These issues have historically proven to be the most complex in nature and take the most time to resolve.

Reviewed and approved by Matt Stohr, Director, Office of Legislative Affairs, Communications and Quality Assurance.

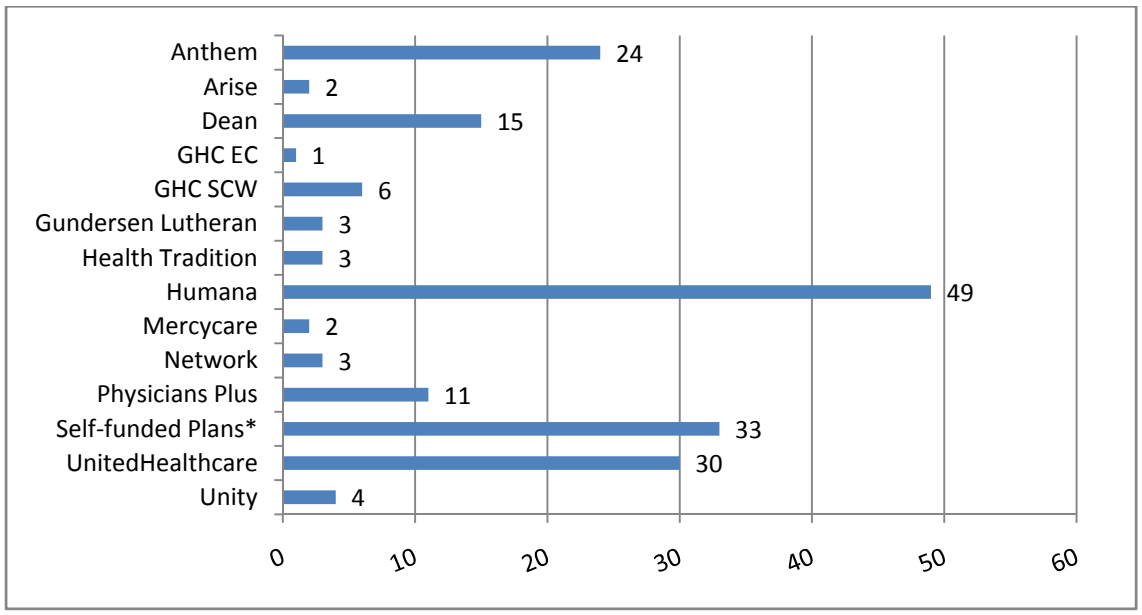
_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	11/10/09	4



Contacts by Health Plan

The 186 Health Insurance complaints for this period are broken down by plan below. Only plans with complaints during this period are shown.

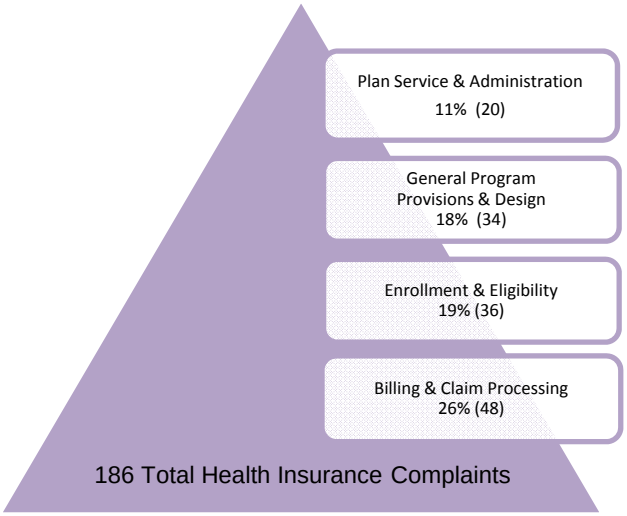


*Self-funded plans are administered by WPS and include: Standard Plan, State Maintenance Plan, Medicare Plus $1 Million, and the Local Annuitant Health Plan.

Contacts by Complaint Type

Throughout the year, billing and claims processing discrepancies are typically the most common reason for contacting Ombudsperson Services. In many cases, members need help understanding and overcoming claim processing or denial issues or are looking for information on the administrative review process.

The four most common complaint types are depicted in the illustration below. However, during this period, members also contacted us regarding matters related to: coordination of benefits, dental services, medical necessity, non-covered services, prior authorizations, unauthorized services and "other."



Trends Observed

Contact topics that occurred at a notable rate during this period include:

- Claims: Member questions and concerns regarding denial of coverage or claim processing errors.

- Enrollment and Eligibility: Member questions about the upcoming *It's Your Choice* period in October as well as questions about current coverage, Uniform Benefits and non-Uniform Benefits plan coverage, how to make changes, dependent eligibility for adult children under the age of 27 and domestic partner enrollment.

- Coordination of Benefits: Member questions regarding order of payment (primary vs. secondary) when member becomes effective under Medicare B or other private insurance.

- Private Fee for Service Medicare Advantage Plan: Member complaints related to passive enrollment when they become Medicare eligible, difficulty and delays in disenrollment, problems with coverage information provided to members by the plan, and claims processing errors.

- Shingles Vaccination: Members incorrectly told by plans that this vaccination is not covered, claims incorrectly denied as non-covered, and members having difficulty being reimbursed when they are directed to purchase product at their pharmacy for administration in their doctor's office.

- Flu Shots: Members report being told by their plan that this is not a covered benefit, claims incorrectly denied as non-covered, and members having difficulty being reimbursed for use of walk-in flu shot clinics.

- Intramuscular and Intravenous Medications: Plans incorrectly refer callers to Navitus for coverage or incorrectly tell members it's not a covered benefit.

- Dental Blue: Members report enrollment and eligibility problems, difficulty getting accurate coverage information, claim delays and incorrect denials, and difficulty identifying network providers. NOTE: The Department of Employee Trust Funds does not administer this benefit.

Ombudsperson program staff will be available at the meeting to answer questions.