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CORRESPONDENCE MEMORANDUM

DATE: May 17, 2010

TO: Group Insurance Board

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

SUBJECT: Annual Ombudsperson Complaint and Inquiry Report

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

This annual report contains information and statistics about the complaints, issues or inquiries raised by Wisconsin Retirement System (WRS) members, their families, employers, and external advocacy organizations about benefits that fall under the authority of the Group Insurance Board (Board).

Ombudsperson (Ombuds) Services reports to the Office of Legislative Affairs, Communication, and Quality Assurance. Ombuds staff attempt to resolve member issues, and provide education and outreach to WRS members. Staff works to ensure that all WRS members have access to timely, accurate, and thorough information regarding benefits administered by the Department of Employee Trust Funds (ETF). Ombuds staff work closely with WRS health plans, third-party administrators such as WPS and Navitus, and with ETF's other benefit programs to ensure that members continue to receive high quality services in the management of their benefits.

When WRS members have a complaint they can request an Ombuds Review related to the administration of or denial of benefits. Ombuds staff attempts to negotiate a resolution of the issue, with the goal of avoiding elevating cases to Departmental Determination or Board Appeal. Issues that Ombuds staff works on can include: prior authorization denials, claims payment issues, coordination of benefits with other health insurance issues; including Medicare, enrollment and eligibility issues, and general issues with plan service and administration.

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

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Signature Date

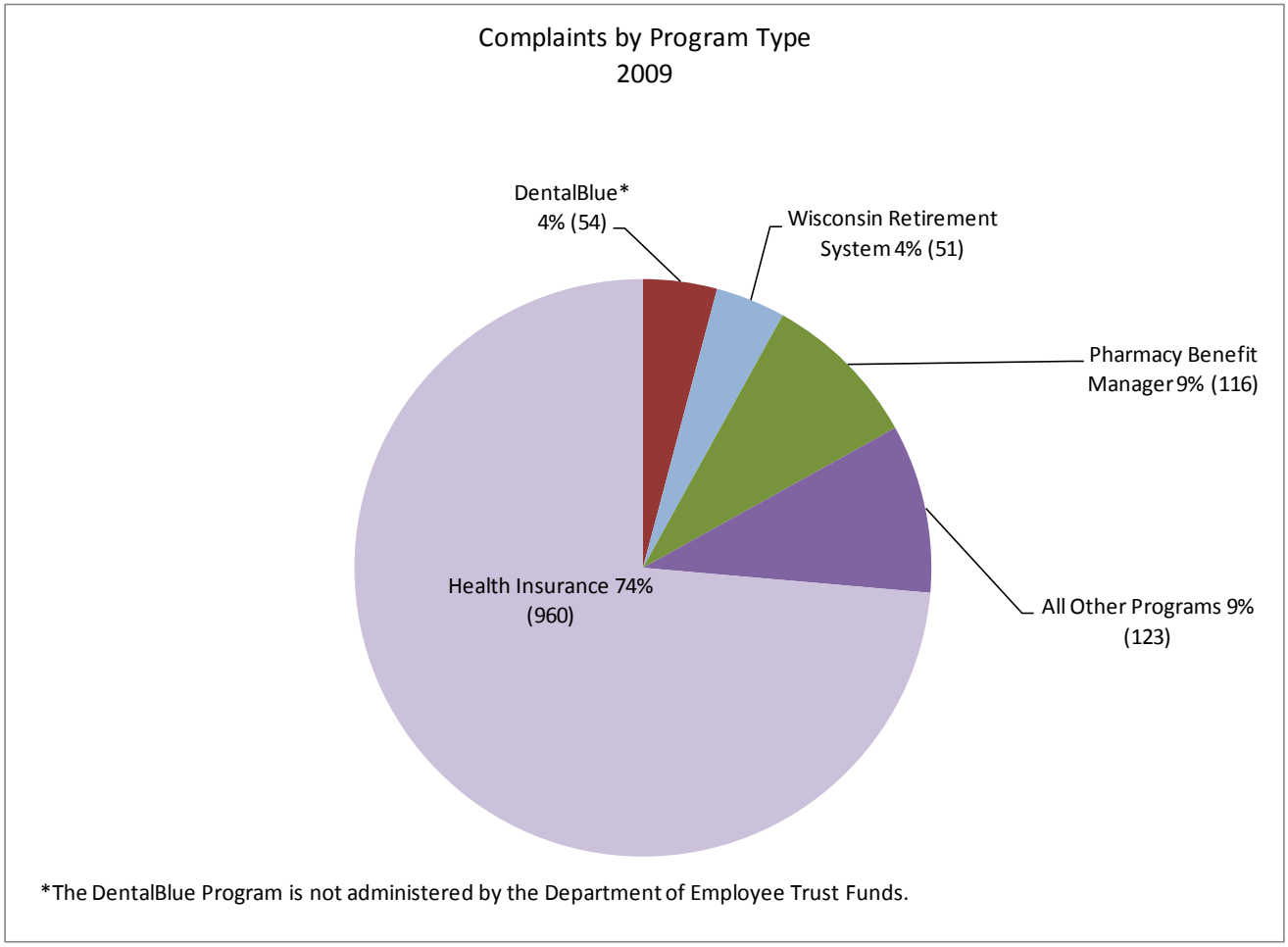
Board	Mtg Date	Item #
GIB	6.8.10	4C

During 2009, Ombuds staff completed 60 written Ombuds Review requests. When reviews were completed, members were given information regarding administrative review rights and instructions on how to request an ETF Departmental Determination. Of the 60 Ombuds reviews this year, 13 subsequently requested a Departmental Determination by the Division of Insurance Services (DIS).

After an Ombuds Review, and if appropriate, some members were advised to consider the option of requesting independent review by an Independent Review Organization (IRO). This also reduces the number of Departmental Determinations.

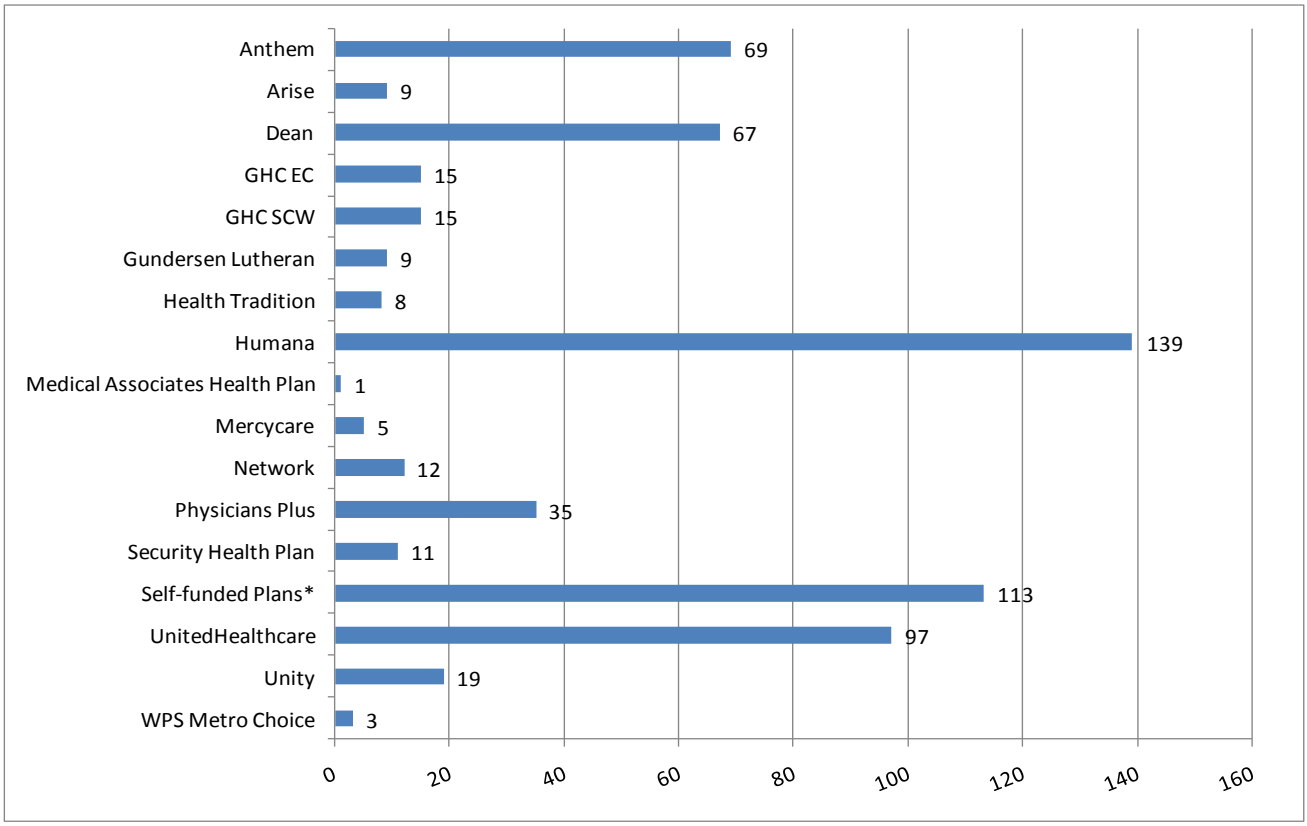
Complaints and Inquiries by Program Type

In 2009, Ombuds staff received a total of 1,304 contacts across all programs. Health insurance continues to be the program that generates the majority of contacts, with 960 contacts (approximately 74%). These issues usually are the most complex and take the most time to resolve.



Complaints and Inquiries by Health Plan

The complaints and inquires for 2009 are broken down by health plan and shown below.



*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 or Inquiry Type

The four most common types of complaints or inquiries for each quarter of 2009 are depicted in the illustration below.

Q1

Enrollment & Eligibility 39% (145)
Billing & Claim Processing 21% (77)
General Program Provision & Design 15% (56)
Plan Service & Administration 11% (42)

Q2

Billing & Claim Processing 27% (76)
Enrollment & Eligibility 21% (59)
General Program Provision & Design 18% (49)
Plan Service & Administration 13% (35)

Q3

Billing & Claim Processing 14% (48)
Enrollment & Eligibility 11% (36)
General Program Provision & Design 10% (34)
Plan Service & Administration 6% (20)

Q4

Enrollment & Eligibility 41% (130)
Billing & Claim Processing 18% (56)
General Program Provision & Design 6% (20)
Prior Authorization 6% (20)

Trends Observed

Specific topics that occurred at a notable rate during 2009 include:

- **Billing and Claim Processing:** Billing and claim processing discrepancies are typically the most common reason members contact Ombuds staff. As noted in the chart, 257 claim contacts were made to Ombuds Services in 2009. This number is approximately 28% of all complaints in the top four categories.
- **Enrollment and Eligibility:** In 2009, enrollment and eligibility discrepancies and inquiries accounted for 370 contacts received by Ombuds staff. There was a significant increase in this category over previous years, which was attributed to requests for assistance with new health insurance eligibility provisions for adult children in 2010. Calls in this category were also related to new Domestic Partner benefit eligibility rules for 2010.
- **General Program Provisions or Design:** Members have concerns about contract provisions and sometimes are requesting a change in program benefits or eligibility provisions. For example, staff receives calls requesting coverage for bariatric surgery with all plans, not just with WPS. Members also call ETF to request coverage for dental implants. Neither of these services are currently covered benefits under the WRS contract.

- **Plan Service and Administration:** This category refers to customer service-related issues. This category is applicable when a member does not receive correct plan coverage information. Example: a member is told his/her plan does not cover shingles vaccinations, vision exams or annual mammography screenings when these services are indeed covered by the health insurance program. Another example: when the plan refers a member to an incorrect resource when in fact the issue clearly falls under the plan's responsibility.
- **Prior Authorization:** There was a noticeable increase in prior authorization calls in the last quarter of 2009, with 20 contacts in the three month period. That is noted as one of the top four categories of calls in the last quarter of the year. Examples: denial of an authorization to see an out-of-network provider; denial of coverage for therapies or medical services that may be deemed by the plan to not be covered under the contract, or to be investigational, experimental, or not medically necessary.

Staff will be available at the June 8, 2010, Board meeting to answer questions.

*Attached, please find a copy of the latest version of the Ombudsperson Services brochure (for Board members and Executive Staff only).