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CORRESPONDENCE MEMORANDUM


DATE: January 11, 2011
TO: Group Insurance Board
FROM: Liz Doss-Anderson, Ombudsperson
Vickie Baker, Ombudsperson
Christina Keeley, Ombudsperson
SUBJECT: Semi-annual Ombudsperson Complaint and Inquiry Report
July 1, 2010 through December 31, 2010

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

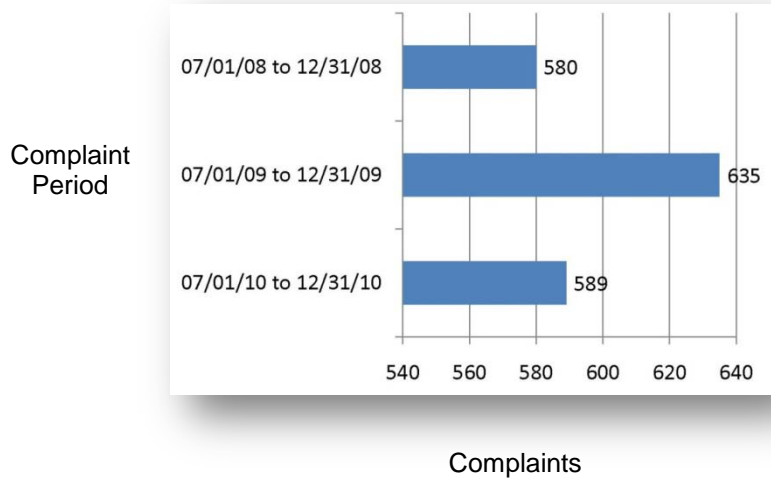
This summary contains information and statistics about the complaints and inquiries related to benefits that fall under the authority of the Group Insurance Board (GIB) and raised by Wisconsin Retirement System (WRS) members, their families, employers and external advocacy organizations.

The Department's Ombudsperson staff attempts to resolve member issues, provide education and outreach to 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.

From July through December 31, 2010, we received 589 complaints and inquiries from members or their representatives regarding benefits, enrollment and eligibility for benefits, billing issues or prior authorizations. In addition, the Ombudspersons assisted 44 members with education/outreach regarding their benefits. The chart on the next page compares contacts during this same period from 2008-2010 and shows how the services provided by the Ombudspersons continues to be a valuable resource to help WRS members resolve their benefit issues.

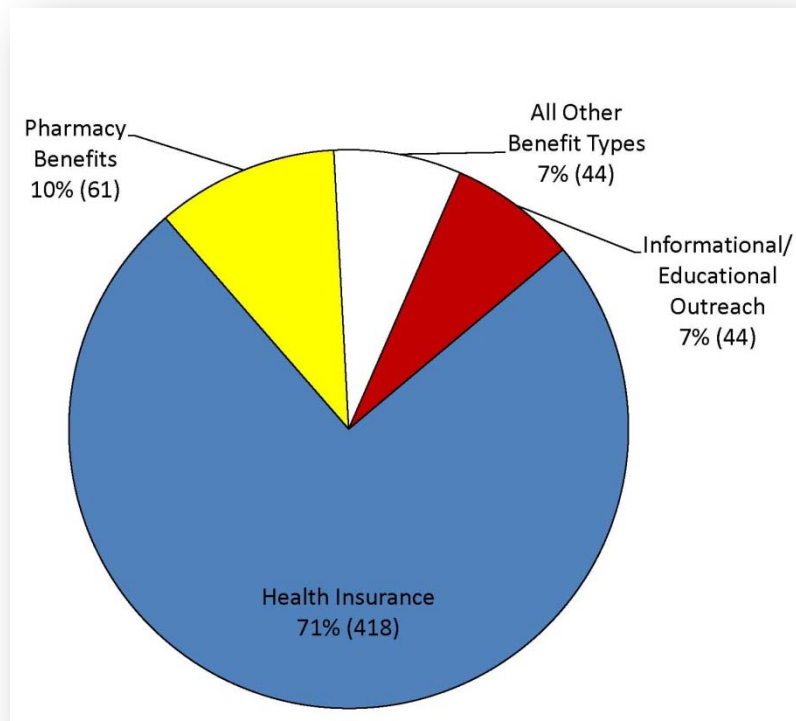
Reviewed and approved by Matt Stohr, Office of Communications and Legislation.

Signature _____ Date 1/20/11

Board	Mtg Date	Item #
GIB	2.8.11	5D



Complaints and Inquiries by Program Type

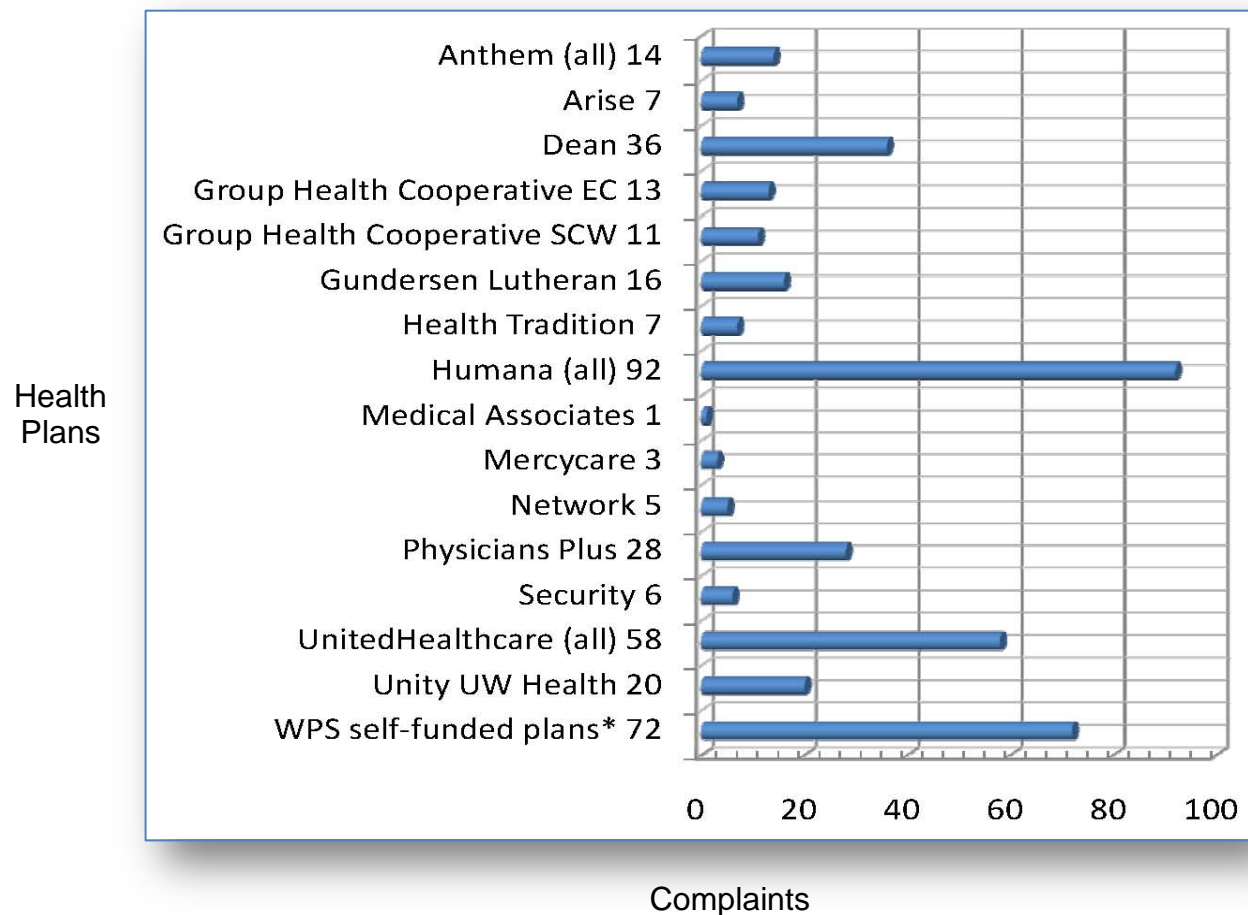
Of the 589 complaints and inquiries, health insurance (418 contacts) continued to be the program that generated the majority of contacts. These issues have historically proven to be the most complex and therefore take the most time to resolve.



Complaints by Program
July 1, 2010 – December 31, 2010

Complaints and Inquiries by Health Plan

The complaints and inquiries for this period are broken down by health plan below. Only plans that we received contacts about during this period are shown.

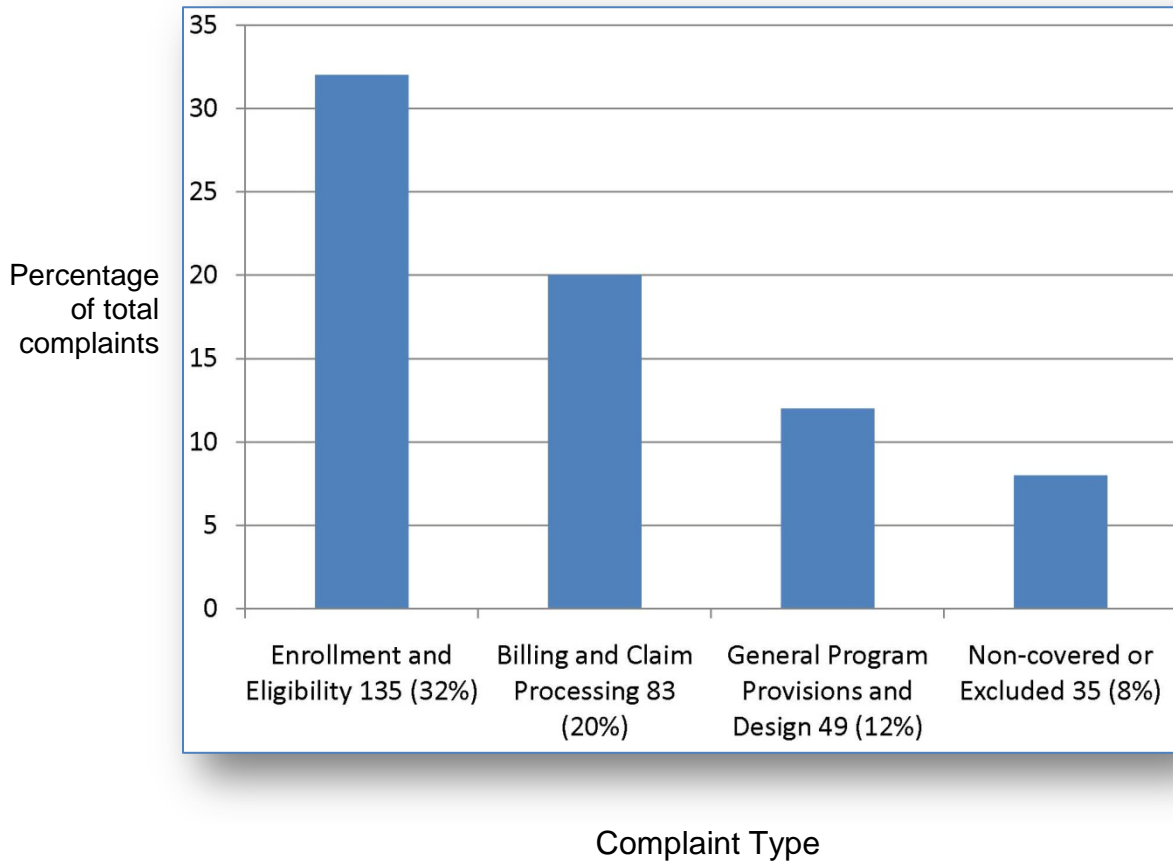


* Self-funded plans are administered by WPS and include: Standard Plan, State Maintenance Plan, Medicare Plus \$1 Million, and the Local Annuitant Health Plan.

Contacts by Complaint and Inquiry Type

Billing and claims processing problems are historically the most common reason members contact Ombudsperson Services. For this reporting period, however, enrollment and eligibility complaints represented 32% of all contacts. Billing and claims processing represented 20% of contacts.

The four most common contact types are depicted below and represent 302 (70%) of the 418 total health insurance contacts for this period.



Trends Observed

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

- **Enrollment and Eligibility:** Many of these contacts involved carry over from the 2009 *It's Your Choice* period, including requests for late enrollment and assistance with initiating services under a new plan. In addition, we received a number of inquiries from members and employers regarding eligibility for domestic partners and adult children up to age 27.
- **Benefit Coverage/Contract Interpretation:** We continue to receive requests from members for assistance in verifying benefits or providing benefit clarification to health plans.
- **Medicare Eligibility and Coordination of Benefits:** We received numerous contacts from members for assistance resolving claim payment issues, eligibility and effective date discrepancies, and premium corrections related to Medicare eligibility and enrollment.

- **General:** Notably, we continue to take advantage of opportunities to educate members on benefit limitations, how to best work with their plans to access care, and the importance of and process for requesting prior authorizations when applicable.

Staff will be available at the February Board meeting to answer questions.