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CORRESPONDENCE MEMORANDUM

DATE: May 13, 2011

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson
Vickie Baker, Ombudsperson
Christina Keeley, Ombudsperson
Office of Communications and Legislation

SUBJECT: Annual Ombudsperson Complaint and Inquiry Report
January 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 raised by Wisconsin Retirement System (WRS) members, their families, employers and external advocacy organizations relating to benefits that fall under the authority of the Group Insurance Board (Board).

The Department's Ombudsperson staff attempt 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 Wisconsin Physicians Service (WPS), Navitus, Aetna, etc.) to ensure plans provide appropriate benefit administration and quality services to WRS members.

From January 1, 2010, through December 31, 2010, Ombudsperson Services received 1,117 complaints from members or their representatives regarding benefits, enrollment and eligibility for benefits, billing issues or prior authorizations. In comparison, in 2009 Ombudsperson Services assisted 1,304 members. The number of contacts indicates that Ombudsperson Services continue to be a valuable resource for WRS members to resolve their benefit issues.

Reviewed and approved by Shawn Smith, Office of Communications and Legislation.

Shawn Smith — Signature

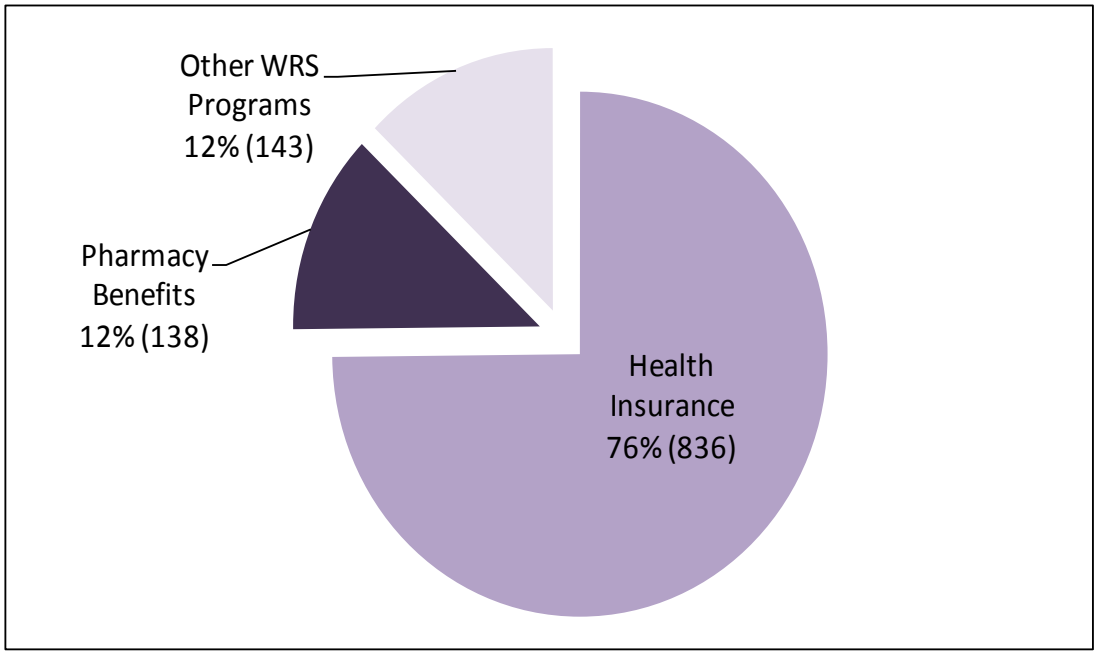
5/19/2011 — Date

Board	Mtg Date	Item #
GIB	6.7.11	10li

Complaints and Inquiries by Program Type

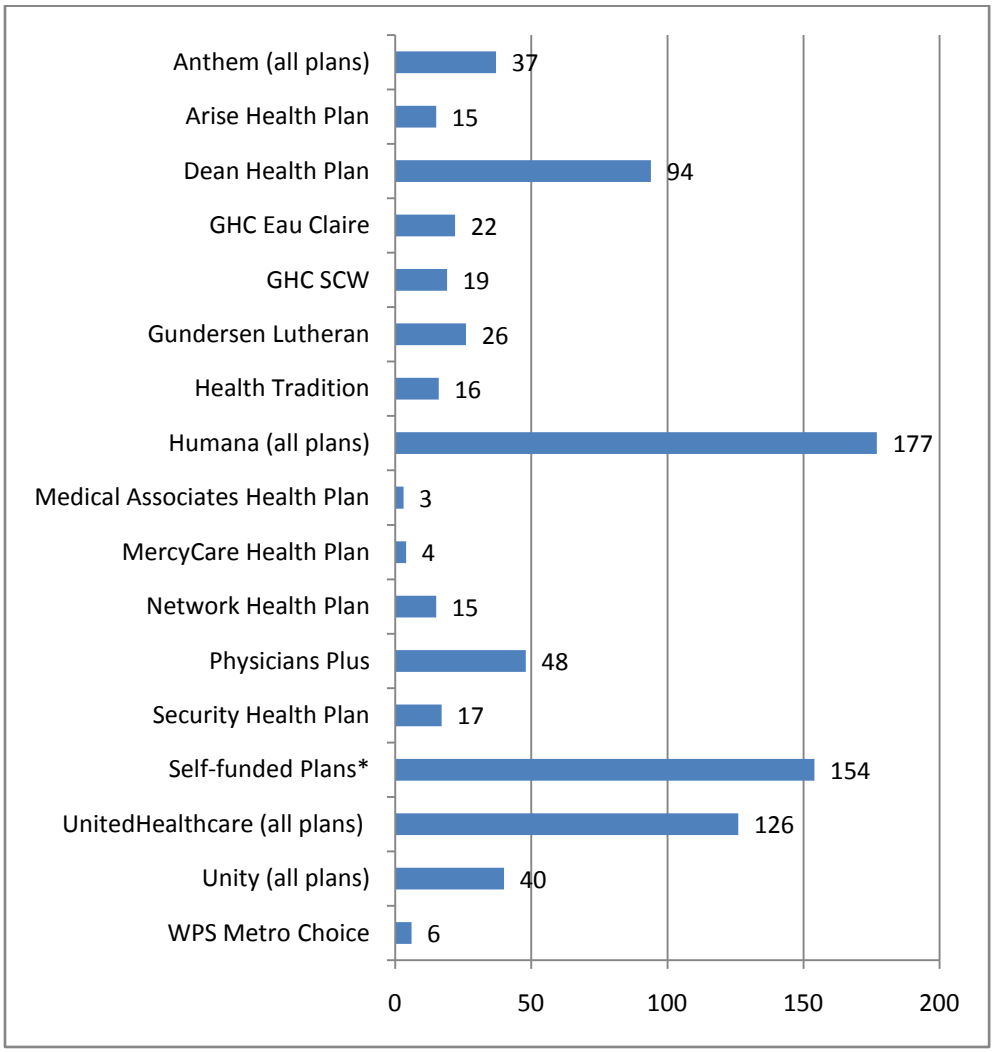
Of the 1,117 complaints and inquiries received in 2010, health insurance continued to be the program that generated the majority of contacts, with 836 (approximately 71%) of all contacts in 2010. Health plan issues have historically proven to be the most complex and, therefore, take the most time for Ombudsperson staff to resolve.

Complaints by Program
January 1, 2010 – December 31, 2010
(rounded to nearest whole percent)



Complaints and Inquiries by Health Plan

The complaints and inquires for calendar year 2010 are broken down by health plan below.

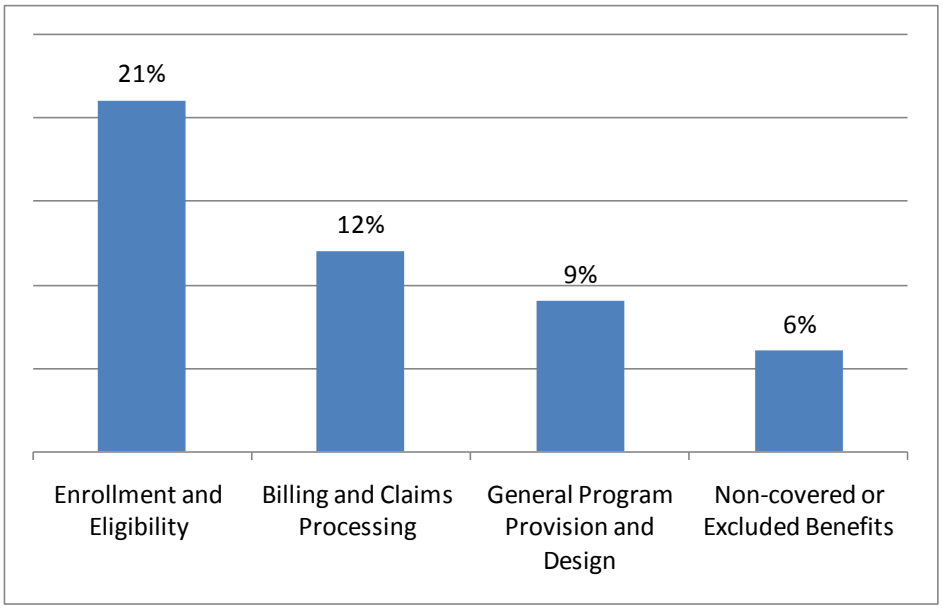


* Self-funded plans are administered by WPS and include: Standard Plan, State Maintenance Plan, Medicare Plus $1 Million, and the Local Annuitant Health Plan.

Contacts by Complaint and Inquiry Type

For the 2010 reporting period, enrollment and eligibility complaints represented a total of 247 contacts (approximately 21%) of all contacts throughout the year. Billing and claims processing problems also generate a significant number of contacts to Ombudsperson Services and represents 138 contacts (approximately 12%) of the total contacts in 2010.

The four most common types of contacts are shown below and account for 560 of the total contacts received (approximately 47%) of the total health insurance contacts for 2010. The other 53% largely consisted of contacts related to prior authorizations, coordination of benefits, medical necessity, plan service and administration, or experimental or investigational service.



Trends Observed

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

- **Enrollment and Eligibility.** Many enrollment and eligibility contacts involve questions regarding health plans offered during the annual It's Your Choice period. Questions generated in 2010 centered on newly-available health plans and the effects of health plan network changes. As in prior years, requests for late enrollment continue to come in after the annual It's Your Choice period ends. In addition, we received a number of inquiries from members and employers regarding the use of myETF Benefits, the new online member portal for health insurance enrollment.
- **Billing and Claims Processing.** We continue to assist members with resolution of claims payment issues on a regular basis and work to ensure that health plans administer member benefits according to the health insurance contract language. Claims processing problems also come to our attention due to Medicare enrollment, coordination of benefits issues, and Medicare effective start date discrepancies.
- **General Program Provision and Design.** In an effort to help members navigate the health care system, Ombudsperson Services takes advantage of opportunities to educate members on benefit plan coverage and the limitations of those plan contracts. Staff assists WRS members on how to best work with their plans to

access care, use their network of providers when applicable, and the importance of and process for requesting prior authorizations when needed.

- **Non-covered or Excluded Benefits.** Significant efforts are made to communicate Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) characteristics and coverage restrictions to health plan members. There will always be some WRS health plan members who are dissatisfied that a service they feel they need is not covered under their health plan contract. Another situation that generates denied coverage for services or additional out-of-pocket costs is when a member is not aware that the provider they see is out of their HMO or PPO network. This can happen if there is a change in a network from one calendar year to the next, or a provider changes clinic or hospital affiliation. Ombudsperson Services works with members to resolve these issues so members can access their plan network and receive covered services.

Ombudsperson staff will be available at the meeting to answer any questions the Board may have.