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CORRESPONDENCE MEMORANDUM

DATE: August 3, 2011

TO: Group Insurance Board

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

SUBJECT: Semi-annual Ombudsperson Complaint and Inquiry Report
January 1, 2011 through June 30, 2011

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 as they relate to benefits that fall under the authority of the Group Insurance Board (GIB).

Trends Observed

Overall, ETF ombudspersons received fewer complaints in the first six months of this year compared to the same time period last year. The chart below reflects total contacts. Last year was unusually busy, due to changes in dependent eligibility rules, launch of online enrollment, and a greater number of employers moving to electronic *It's Your Choice* books. Ombudsperson Services continues to be an important resource for members to resolve benefit issues.

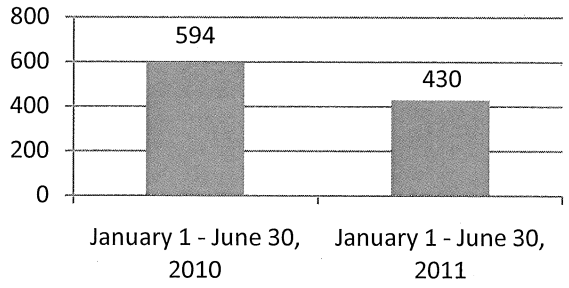
Reviewed and approved by Shawn Smith, Director, Office of Communication and Legislation.

Shawn Smith — Signature

8/11/11 — Date

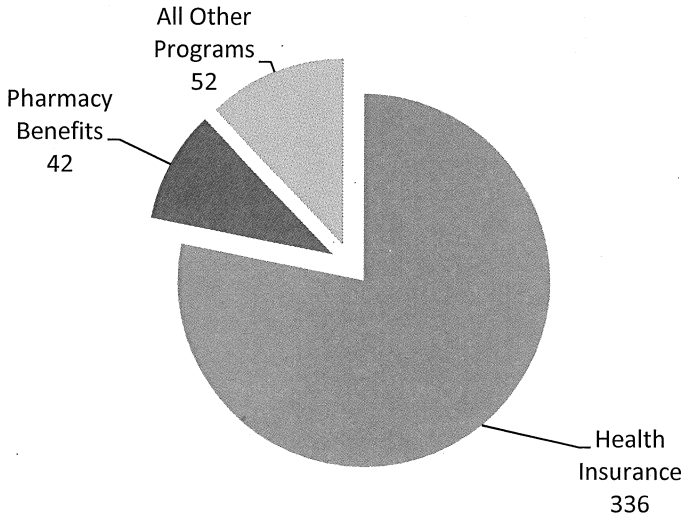
Board	Mtg Date	Item #
GIB	8.23.11	10F

Complaint Comparison: Jan-June 2010 and 2011



Of the 430 complaints and inquiries, health insurance continued to be the program that generated the majority of contacts, with 336 (78% of the total). This program has historically proven to present the most complex complaints, which generally take the most time to resolve.

Complaints by Program Type
January 1, 2011 – June 30, 2011



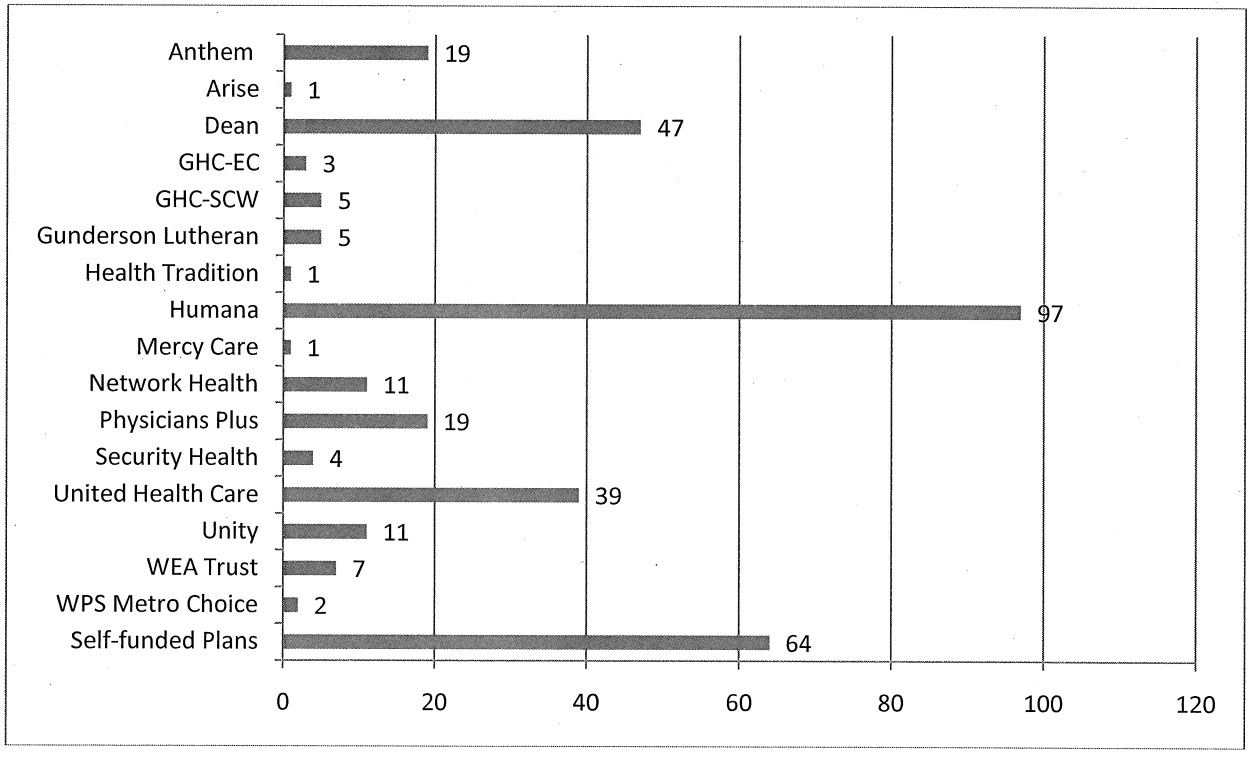
High workload levels contributed to an increase in billing and claims processing issues. ETF received 71 complaints about billing and processing in this last review period (17% of the total number of complaints). During this six-month period, due to an overwhelming number of retirement applications that needed processing, ETF staff was unable to keep up with the system updates needed to continue health insurance coverage into retirement. These members had a gap in coverage when their employer contribution ended. This issue has since been resolved with additional ETF staff hires.

Also, some ETF system complications can impede timely access to services for some members. Updating ETF's internal system often requires a sequence of changes spread out over several days, due to the multiple processing steps and systems used. Occasionally, members need services during that time and do not have access to real-time pharmacy benefits during the time delay. The multiple-day effort also is somewhat susceptible to human error – employees losing track of a change or missing a step. This internal training issue has been addressed when necessary.

There was improvement in the number of complaints related to enrollment and eligibility. (65 complaints, 15% of the total number of complaints) This number is down from 135 complaints in the previous six-month period. The higher volume of complaints in the preceding six-month period coincides with the launch of My ETF Benefits and the difficulties or questions members and employers had related to using the new system.

Complaints received by ETF are highly concentrated in several health plans. The chart below shows the complaints and inquiries for January through June of 2011 based on the contacts for each health plan. Only plans that we received contacts about during this period are shown.

Complaints by Plan
January 1, 2011 to June 30, 2011



Three plans accounted for 62% of all complaints contacts during this period (208 of 430). Humana continues to lead, with 97 complaints (29% of total). WPS had 64 (19%) of the health plan complaints and Dean accounted for 47 (14%) of the complaints we received. These plans have a high numbers of participants, however, and it is unclear if the rate of complaints is out of proportion to the number of covered members.

Although enrollment and eligibility, claims processing, and service and administration are on-going issues, frequent queries relate specifically to the Humana Group Medicare Advantage plan.

Ombudsperson staff worked with several plans in past years to jointly maintain a log of complaints and the status of those issues so as to facilitate their resolution. At this time, we continue to utilize such a tool with Humana to track new and unresolved issues.

Plans sometimes fail to make timely system changes, resulting in an incorrect denial of coverage. Claim issues come to our attention when plans do not correctly process coverage under the state contract. This typically happens with services such as hearing aid purchases, vaccinations, annual physicals, eye exams, and other preventive care.

Plans have been cooperative when asked to run system queries to check for other members who have had similar claims denied in error, so that the claims can be detected and corrected.

Health Insurance Plans need to continue their efforts to improve call center staff training. (35 complaints, 8% of the total number of complaints) Recurring issues with service and administration often result from a lack of training for plan call center staff resulting in WRS members receiving incorrect information about their benefits. This can lead to members not getting services or paying out-of-pocket for services the plan should cover.

Looking ahead to the next reporting period, ombudsperson staff anticipates that the next six months will pose new challenges for ETF staff and the health plans. We anticipate a strong need to increase educational efforts for members, employers, and staff regarding new health insurance contract changes. To that end, we look forward to assisting with outreach efforts and to monitor how plans update their claims systems to correctly reflect and accommodate the changes.

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