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CORRESPONDENCE MEMORANDUM

DATE: August 1, 2014

TO: Group Insurance Board

FROM: Allen Angel, Ombudsperson
Vickie Baker, Ombudsperson
Liz Doss-Anderson, Ombudsperson
Dan Hayes, Attorney/Supervisor

SUBJECT: Semi-Annual Ombudsperson Contact Report
January 1, 2014 through June 30, 2014

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

This report contains information about complaints and inquiries received by the Department of Employee Trust Funds (ETF) Ombudsperson Services staff. Complaints and inquiries are received from members, their families, employers, and external advocacy organizations and are related to benefits under the authority of the Group Insurance Board (Board).

From January 1 through June 30, 2014, Ombudsperson Services received 479 complaints and inquiries from members or their representatives, approximately the same number as compared to the first six months of 2013. As in the past, the health insurance plans generated the majority of contacts, with 230 complaints and inquiries (approximately 48% of the total). A chart showing the breakdown of these complaints and inquiries by health plan can be found on page four of this report.

ETF program administration issues caused the second largest number of contacts, with 193 (40% of the total). The majority of these contacts related to the health insurance program, but involved general inquiries and other issues that did not touch on any activity by the health plan. The health insurance and pharmacy benefit programs involve the most complex and time consuming issues for staff to resolve.

Most of the contacts were related to the following categories:

- General program provisions and design
- Enrollment and eligibility

Reviewed and approved by David Nispel, General Counsel, Legal Services

David H. Nispel

Electronically Signed:
08/08/2014

Board	Mtg Date	Item #
GIB	08.26.14	8F

- Billing or claims processing discrepancies

Additional categories with noticeable complaint and inquiry numbers were:

- Premium issues
- Plan service and administration
- Non-covered or excluded benefits

Ombudsperson Services staff continued to help members understand various aspects of their health insurance, including coordination of benefits, prior authorization requirements, and dental coverage.

Ombudsperson Services staff assisted members with 164 complaints and inquiries regarding general program provisions or design. Other complaint and inquiry categories are considerably smaller. Enrollment and eligibility had 64 contacts; billing and claims, 38 contacts; premium issues, 36 contacts; plan service and administration, 36 contacts.

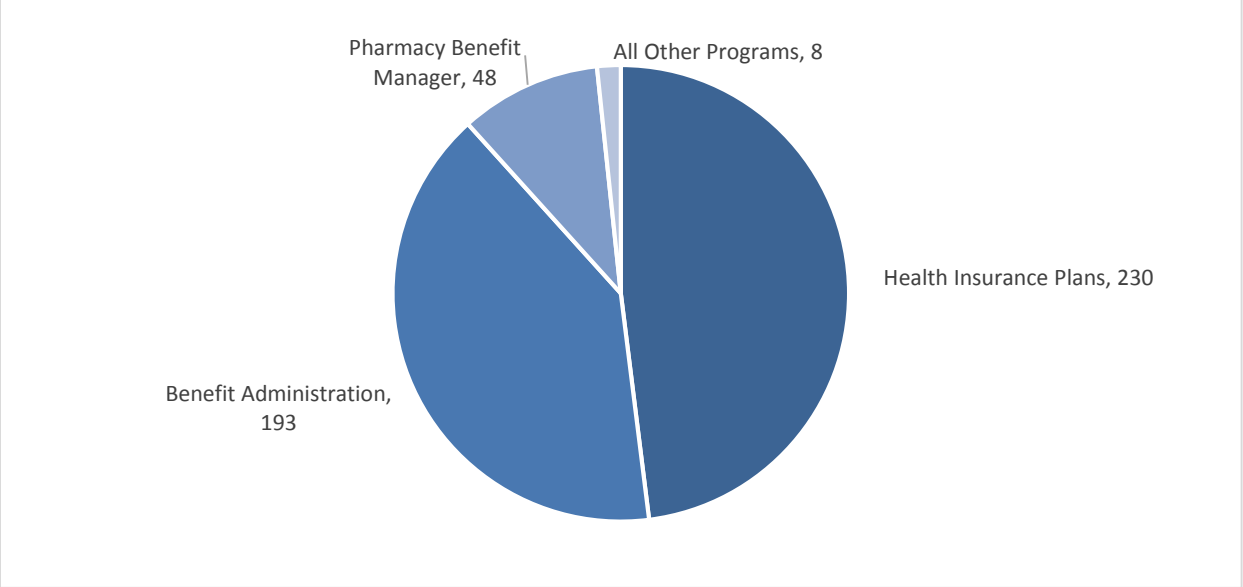
The high number of contacts related to general program provisions and design in part reflects contract changes for 2014. For example, the Uniform Benefit Dental Contract for 2014 was a significant change from how the health insurance program had been structured in previous years. For some members, the change enhanced their dental benefits, but for others it decreased their benefits. For example, a few of our plans offered dental crown coverage in 2013. Some members who had this type of coverage discovered that the pre-crown services received in 2013 were covered, but the crown received in 2014 was not. Other members were unaware of the January 1, 2014 change to uniform dental benefits and sought services that were no longer covered in 2014.

The Uniform Dental Contract also caused some plans to make significant changes to in-network dental providers for 2014. We received many calls from members whose claims were not paid because they received services from their long-time dentist, who was considered out-of-network for 2014.

Members who experienced a decrease in benefits or had unpaid dental claims were frequent callers to Ombudsperson Services the first six months of 2014. Ombudsperson staff continue to educate members about the new dental contract provisions and help members avoid unpaid dental claims in the future.

In the chart below, general program provision and design contacts encompass a significant majority of the issues included in the Benefit Administration category. This category reflects issues raised by members that are not related to an action taken by their health plan. For example, if a member was upset because a specific benefit was not covered in the health plan’s contract, the issue was attributed to benefit administration rather than to the health plan because all plans are required to follow contract provisions.

Complaints and Inquiries
January 1, 2014 – June 30, 2014



All Other Programs Include: life insurance, Employee Reimbursement Account, Income Continuation Insurance, Local Annuitant Health Plan, AERNA/LTDI, VSP, Sick Leave Account, etc.

Another factor that helps account for the increased number of Benefit Administration contacts in the first six months of 2014 was the enhancements to the MyETF Benefits system (MEBS). These enhancements allow data obtained through the Voluntary Data Sharing Agreement (VDSA) to update members' Medicare enrollment information in MEBS. The VDSA enables ETF and the Centers for Medicare and Medicaid Services (CMS) to share enrollment and eligibility information in order to transition our members to a Medicare coordinated contract under the group health insurance programs, including enrollment in the Navitus Medicare RX program.

The project to incorporate the VDSA data included a one-time update to CMS in early 2014 that included group health insurance program enrollment information going back to January 1, 2012. This retroactive update of information to CMS inadvertently affected some members' current enrollment in the Navitus MedicareRx (PDP) plan. These enrollment errors were corrected manually by ETF. We do not expect this issue to come up again because future Medicare enrollment updates from CMS will only be prospective.

Looking Ahead

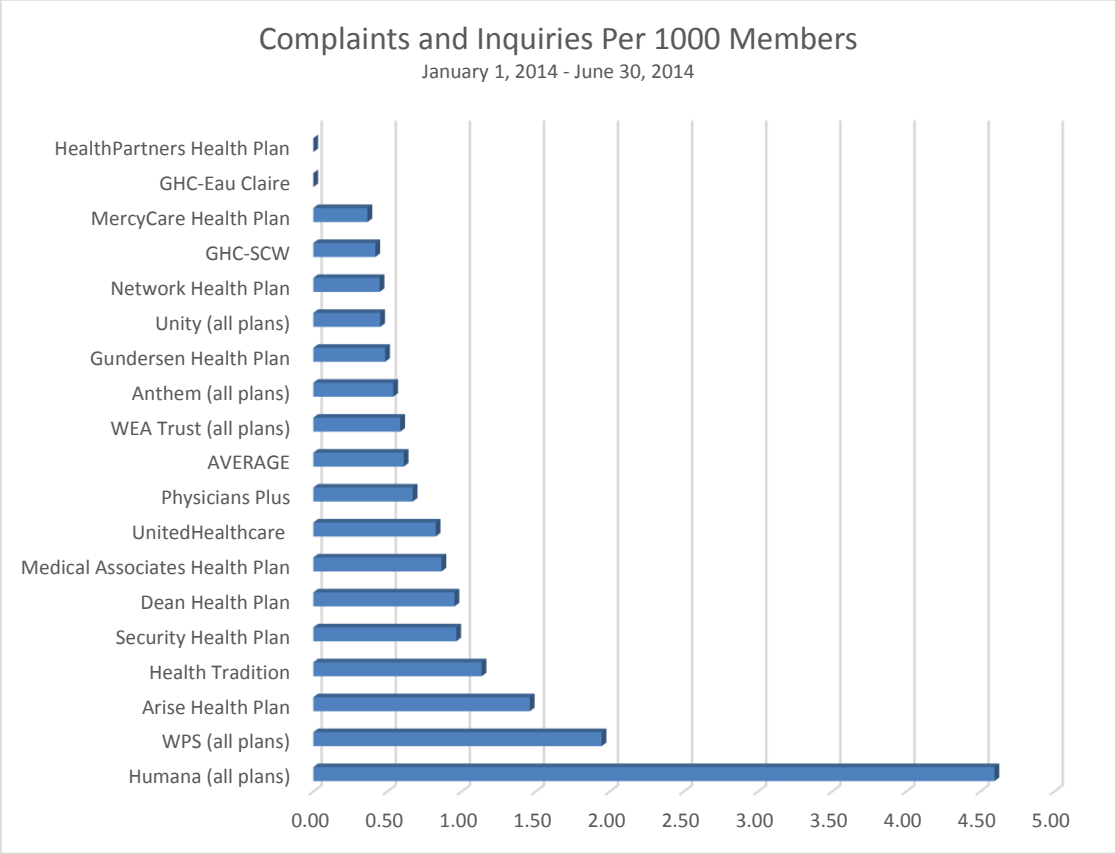
During the second half of 2014, Ombudsperson Services staff will stay involved with preparations for the annual Its Your Choice (IYC) open enrollment activities, including

review of the IYC guides, participation in the IYC Employer Kickoff event, internal staff trainings and employer health fairs across the state. This year we anticipate inquiries from members who want to better understand the difference between traditional Uniform Benefits and the new High Deductible Health Plan that will be available in 2015. We also anticipate receiving questions about how the new program will be administered by the health plans and the pharmacy benefit manager. Staff also continues to participate in the enhancements to ETF systems in general, as part of various Benefits Administration System projects.

While the number of Independent Review (IR) requests have remained consistent with prior years, staff continue to monitor the total number of IR determinations for increases and decreases. It is important for members who need assistance to understand the review options available to them, along with changes to the administrative review process and its relationship to medical necessity and experimental treatment denials.

As always, we continue to emphasize early intervention in the resolution of all matters. Our goal is to keep the number of Board appeals at a minimum. As a result, our resources can be better used to focus on quality assurance and enhance member education. This approach allows us to maintain high quality customer service and improve the administration of all WRS benefit programs.

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


Complaints and Inquiries Per 1000 Members
January 1, 2014 - June 30, 2014
HealthPartners Health Plan
GHC-Eau Claire
MercyCare Health Plan
GHC-SCW
Network Health Plan
Unity (all plans)
Gundersen Health Plan
Anthem (all plans)
WEA Trust (all plans)
AVERAGE
Physicians Plus
UnitedHealthcare
Medical Associates Health Plan
Dean Health Plan
Security Health Plan
Health Tradition
Arise Health Plan
WPS (all plans)
Humana (all plans)
0.00
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1.00
1.50
2.00
2.50
3.00
3.50
4.00
4.50
5.00