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Correspondence Memorandum

DATE: July 31, 2015

TO: Group Insurance Board

FROM: Allen Angel, Ombudsperson
Vickie Baker, Ombudsperson
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Dan Hayes, Attorney/Supervisor

SUBJECT: Semi-Annual Ombudsperson Contact Report
January 1, 2015 through June 30, 2015

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, 2015, Ombudsperson Services received 509 complaints and inquiries from members or their representatives, a small increase in comparison with the first six months of 2014. As in the past, actions of health insurance plans generated the majority of contacts with 190 complaints and inquiries, approximately 38% of the total. This compares with 230 contacts in 2014. A chart showing the breakdown of these complaints and inquiries by health plan can be found on Page 5 of this report.

Members with ETF program administration issues resulted in the second largest number of contacts, with 152, or 31%, of the total. The majority of these contacts related to the health insurance program, but involved general inquiries and 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: 8/11/15

Board	Mtg Date	Item #
GIB	08.25.15	8F

- Billing or claims processing discrepancies

Additional categories with noticeable complaint and inquiry numbers were:

- Non-covered or excluded benefits
- Plan service and administration
- Prior authorizations

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

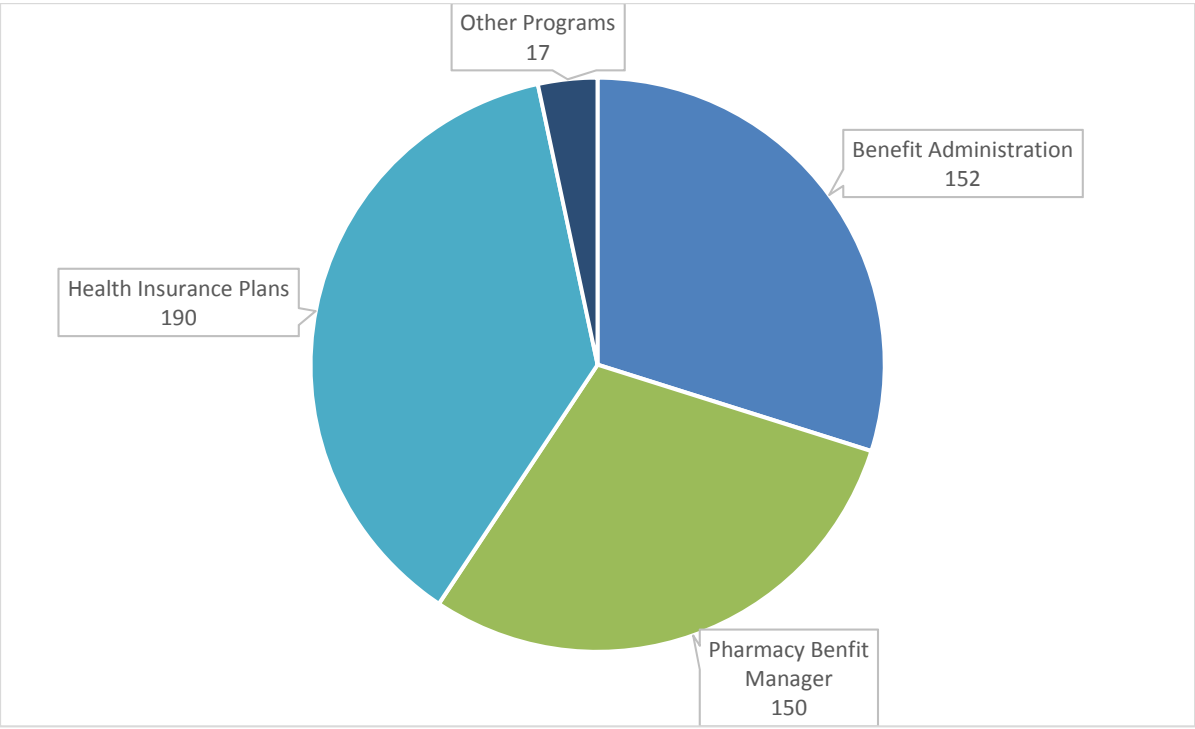
Staff assisted members with 179 complaints and inquiries regarding general program provisions or design. The second highest complaint and inquiry category was enrollment and eligibility with 143 contacts, a significant increase compared to 64 in the first six months of 2014. This increase was due in large part to issues attributed to the pharmacy benefit program and the various factors explained on Page 3 below. Other contact categories are smaller and are as follows: billing and claims (40 contacts), non-covered or excluded benefits (34 contacts), premium issues (24 contacts).

The higher number of contacts related to general program provisions and design, in part, reflects contract changes for 2015. For example, in 2015, all health plans were required to offer a High Deductible Health Plan (HDHP) option. This was a significant change for our members, requiring them to evaluate the new option and determine if it met their health insurance and economic needs.

The Uniform Dental Benefit, also under the contact category of general program provisions and design, continued to generate a high number of inquiries. Even though the change to Uniform Dental Benefits was first implemented in January of 2014, a number of members still had questions and concerns about loss of a long-time in-network provider or a decrease in the dental benefit package offered by their specific health plan. Both of these changes were a result of the new Uniform Dental Benefit.

In the chart on the next page, 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 Inquires
January, 1 2015 to June, 30 2015



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

The chart also demonstrates an increase in the number of contacts associated with the Pharmacy Benefit Manager (PBM). Navitus contracted with a new Medicare D administrator for 2015, and that change led to many of the member enrollment issues.

ETF continues to use data obtained through the Voluntary Data Sharing Agreement (VDSA) to update members' Medicare enrollment information in myETF Benefits. VDSA enables ETF and the Centers for Medicare and Medicaid Services (CMS) to share enrollment and eligibility information about members who are enrolled in Medicare. The VDSA and CMS databases take time (sometimes weeks or months) to coordinate and update information. A number of members were denied pharmacy benefits under the Navitus Medicare D Rx program until obsolete insurance information was removed. Issues of this type resulted in our PBM contacts tripling from 48 in in the first half of 2014 to 150 in the same time period in 2015.

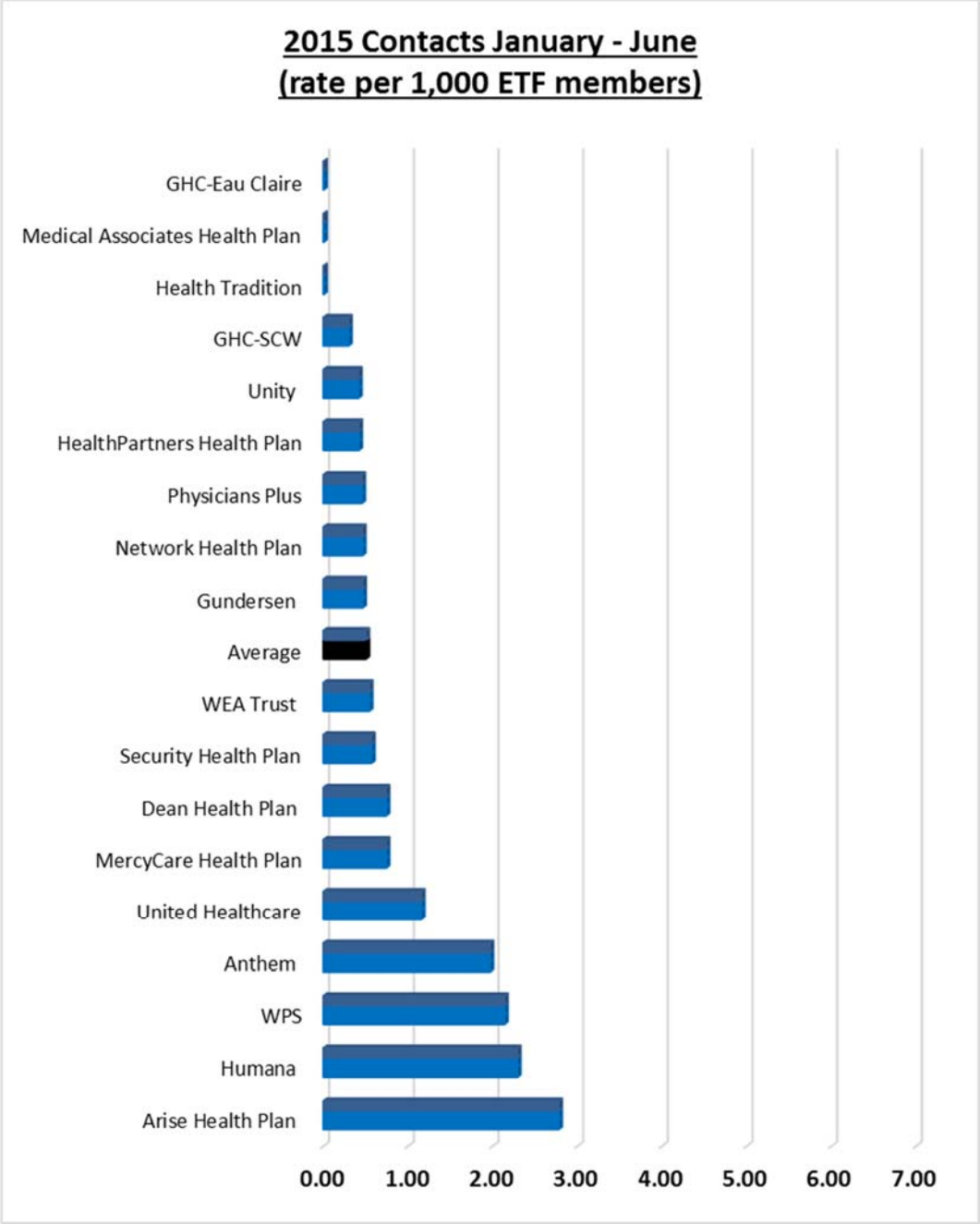
Looking Ahead
During the second half of 2015, Ombudsperson Services staff will stay involved with preparations for the annual It's Your Choice (IYC) open enrollment activities, including

review of the IYC member materials, participation in the IYC Employer Kickoff event, state-wide employer health fairs and internal staff trainings. Staff also continues to participate in the enhancements to ETF computer systems as part of Benefits Administration System-related projects.

There are significant cost sharing increases for our members in 2016. These increases include first-time deductibles, increased out-of-pocket limits, coinsurance for certain prescription drugs and office visit copayments. Three out of four of these increases will be new to the State of Wisconsin Group Health Insurance Program and, as a result, IYC education becomes even more important. We anticipate numerous inquiries in both late 2015 and throughout 2016 as members begin paying more out-of-pocket costs. Ombudsperson Services also expects additional interest and questions about the HDHP, based on its recent introduction (2015) and the 2016 increases in employer contributions for Health Savings Accounts (HSA) associated with the HDHP option. The HSA changes, coupled with increased costs for the coinsurance Uniform Benefits (UB) plan, will generate inquiries from members who want to better understand the difference between a traditional UB plan and the HDHP as economics become more prominent in health insurance decisions.

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 enhancements to 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.


2015 Contacts January - June
(rate per 1,000 ETF members)
GHC-Eau Claire
Medical Associates Health Plan
Health Tradition
GHC-SCW
Unity
HealthPartners Health Plan
Physicians Plus
Network Health Plan
Gundersen
Average
WEA Trust
Security Health Plan
Dean Health Plan
MercyCare Health Plan
United Healthcare
Anthem
WPS
Humana
Arise Health Plan
0.00
1.00
2.00
3.00
4.00
5.00
6.00
7.00