STATE OF WISCONSIN
DEPARTMENT OF EMPLOYEE TRUST FUNDS
801 West Badger Road
Madison, WI 53702

CORRESPONDENCE MEMORANDUM

DATE: May 12, 2003

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson, Quality Assurance Services Bureau
Christina Licari, Ombudsperson, Quality Assurance Services Bureau

SUBJECT: Health Plan Grievances and Independent Review Report

This report on health plan grievances and independent review activity is provided for informational purposes. This report is used to identify notable trends within the health and disability insurance programs that warrant attention by the Department. A summary chart of the data will also be included in the Report Card section of the *2004 It's Your Choice* booklet.

I. 2002 Health Plan Grievance Report for State of Wisconsin & Local Employees

This report summarizes annual data provided to the Department by all plans participating in the state health insurance program. The report was compiled by reviewing each plan's annual grievance report, which was submitted on March 1. Notable highlights include:

- The total number of grievances reported by health plans continued on a three-year decline with 778 grievances reported in 2002 compared to 835 in 2001 and 942 in 2000.
- The percentage of grievances with outcomes in favor of the member ("overturned") stayed consistent with past years at 51%. However, Atrium and CompcareBlue NE experienced "overturn" of over 90%.
- The grievance category with the most grievances across all plans concerned non-covered services (26.3%). Unauthorized service grievances were also high again this year at 16.8% of the total reported. The majority of these types of complaints involve members seeking health care outside of their plan service area or network without prior authorization from the plan.
- ETF staff have noticed an increase in grievance decisions in which the health plan denied a service or benefit as non-covered or excluded. For example, one health plan's non-covered benefit or excluded service denials increased from 8 in 2001 to 21 in 2002. This trend may be attributed to the implementation of the independent review (IRO) process, which does not require the listing of IRO rights for specific contract exclusions. This indicates a need to monitor health plan grievance decisions to ensure that all health plans are citing the appropriate reasons for benefit denials.

The attached charts depict each health plan's grievance activity in more detail.

II. 2002 ETF Independent Review Report

This report provides a summary of independent reviews that were requested by ETF health insurance members who may or may not have completed some or all of the administrative review process at ETF. The independent review process was a new avenue of appeal available to State of Wisconsin health program consumers that began in June 2002. To be eligible for an independent review organization (IRO) review, a member must have an adverse determination involving a claim or service that was denied as not medically necessary, experimental or for an out-of-network referral. This process allows members, for a fee of $25.00, the opportunity to have an independent consultant review their grievance to determine if benefits are payable. The IRO's decision is binding on both the health plan and the member. Health plans are required to notify ETF when a member requests an independent review and provide ETF with notification of the outcome of the independent review.

In 2002, health plans notified ETF of 14 requests for independent reviews by State of Wisconsin health program members. Of the 14 reviews requested, 5 (36%) reviews resulted in favorable resolutions for the members, while 7 (50%) reviews upheld the original health plan decision. In addition, the IROs declined to review two requests, as it was determined that the requests did not meet the necessary criteria to be reviewed by an IRO. Most of the reviews requested involved medical necessity denials, requests to see a non-plan provider for diagnosis or treatment, pharmaceutical issues and therapy services.

The Quality Assurance Services Bureau is responsible for ongoing education of members regarding the IRO process. When the Department processes a new health insurance complaint, it is reviewed by the ombudsperson, and if appropriate, the member is contacted and educated about the advantages and disadvantages of requesting an IRO. The Department also monitors health plan grievance decision letters to members to assure that members are being given their IRO rights, when appropriate.

We will be available at the meeting for questions. Thank you.

Attachments