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CORRESPONDENCE MEMORANDUM

DATE: May 17, 2004

TO: Group Insurance Board

FROM: Liz Doss-Anderson, 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. We use this information 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 *2005 It's Your Choice* booklet.

I. 2003 Health Plan Grievance Report for State of Wisconsin & Local Employees

Below is a summary of 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, 2004. A grievance is defined as any dissatisfaction with a provision of services or claim denial that is submitted in writing to the insurer by or on the behalf of a member. Notable highlights include:

- The total number of grievances reported by health plans continued on a four-year decline with 744 grievances reported in 2003 compared to 778 in 2002 and 835 in 2001.
- The percentage of grievances with outcomes in favor of the member ("overturned") increased in 2003 to 60% compared to 2002 when the overturn rate was 51%. Both Humana Eastern and Humana Western experienced "overturn" rate of over 85%.
- The grievance category with the most grievances across all plans concerned non-covered services (26.3%). The three most common types of non-covered services included gastric bypass, durable medical equipment items and various non-traditional therapy services including speech therapy, educational therapy and massage therapy. Unauthorized service grievances were also high again this year at 16.4% of the total reported. In addition, grievances related to billing and claims processing issues spiked this year and accounted for 13.8 % of all the grievances filed by our members
- Grievances involving problems obtaining a referral declined in 2003. In previous years, referrals generally accounted for approximately 15% of all grievances filed. In 2003, grievances related to the referral process dropped to 7.5%. This demonstrates that the Department's ongoing efforts to work with health plans to ensure member materials accurately describe their referral and prior authorization requirements has been successful.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

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Signature Date

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II. 2003 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.

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.

In 2003, health plans notified ETF of nine requests for independent reviews by State of Wisconsin health program members. Of the nine reviews requested, only one (11%) of the reviews, involving the denial of coverage of a durable medical equipment item, resulted in favorable resolutions for the member, while eight (89%) of the reviews upheld the original health plan decision. Most of the reviews requested involved the denial of coverage for a treatment because the treatment did not meet the definition of medical necessity.

The number of IRO requests reported by health plans has continued to be a low number in comparison to the total number of denials based on medical necessity or experimental treatment. Therefore, the Department will continue to work with health plans to ensure plans are compliant with use of IRO language in grievance decision letters to members. In addition, the Department will make certain that plans are complying with their contractual obligation to report all independent review requests made by our members to ETF.

The attached charts depict each health plan's grievance activity in more detail. We will be available at the meeting for questions. Thank you.

Attachments