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CORRESPONDENCE MEMORANDUM

DATE: May 18**,** 2005

TO: Group Insurance Board

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

SUBJECT: Health Plan and Pharmacy Benefit Manager Grievance and Independent Review Report

This report on health plan grievances and independent review activity is provided for informational purposes. This information is used to identify notable trends within the health insurance and pharmacy benefit manager (PBM) programs that warrant attention by the Department. A summary chart of the data will also be included in the Report Card section of the *2006 It's Your Choice* booklet. Beginning with the 2005 plan year, grievances related to the PBM program, which is administered by Navitus Health Solutions, will be reported to the Board separately.

I. 2004 Grievance Report for State of Wisconsin and Local Employees

Below is a summary of annual data provided to the Department of Employee Trust Funds (ETF) by all plans participating in the state group health insurance program, including the PBM program. The report was compiled by reviewing each plan's annual grievance report. The grievance reports were submitted to ETF on March 1, 2005. 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 behalf of a member. Notable highlights include:

- The total number of health plan grievances reported for 2004 was 741. This marks the fifth consecutive year that the total number of grievances has declined from the highest total of 942 in 2000.
- In 2004, 11 of 21 plans experienced outcomes in favor of the member (overturns) for greater than 50% of their total grievances. Two plans had overturn rates of 86% and 83%.

  While high overturn rates demonstrate the benefit to members of utilizing the plan grievance process, it may also signify a need for ETF staff to work with plans to ensure consistent interpretation and application of Uniform Benefits.
- The grievance categories with the most grievances across all plans in 2004 were unauthorized services (31.7%), non-covered services (27.8%), and quality of care (9.2%). In 2003, the categories with the most grievances were non-covered services (26.3%), unauthorized services (16.4%), and billing and claim processing problems (13.8%).

Reviewed and approved by Pam Henning, Administrator, Division of Management Services.

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Signature Date

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Historically, billing and claim processing problems has been one of the grievance types with the highest frequency. In 2004, grievances regarding quality of care concerns exceeded those regarding billing and claim processing.

A correlation may be drawn between the emergence of quality of care as a common grievance type in 2004 and an increase in consumer awareness regarding patients' rights. This may also be attributable to ETF's continued efforts to promote value-based health care purchasing and improved patient education through the Department's newsletters, "It's Your Choice" booklets, and Web site.

- Health plan grievances involving problems obtaining a referral remained relatively low in 2004 at 9.2% compared to 7.5% in 2003. In previous years, referrals generally accounted for approximately 15% of all grievances filed.
- Health plan grievances involving unathorized services increased from 16.4% in 2003 to 31.7% in 2004. Two health plans accounted for over 50% of the total unauthorized services grievances filed by members.

  This may indicate a need for ETF to evaluate how well the plans communicate the requirements of and procedures for obtaining approved referrals prior to services being rendered.
- The total number of PBM grievances for 2004 was 494. The overturn rate for PBM grievances in 2004 was 23%. The grievance categories with the most grievances were copayment reduction (54%), non-covered items (37.7%), and prior authorization (7.1%). These figures are reflective of the implementation of the new, single PBM, including the change from a two-level formulary design to a three-level design.

II. 2004 ETF Independent Review Report

This report provides a summary of independent review (IR) requests by ETF members. Participants who request IRs must have completed the plan grievance process and may have completed all or part of the administrative review process available within ETF.

The independent review (IR) process, which was created by the Office of the Commissioner of Insurance in 2002, has continued to be a valuable avenue of appeal for consumers. To be eligible for a review through an independent review organization (IRO), a member must have an adverse determination (grievance decision) involving an out-of-network referral or a denial of a claim or service deemed by the plan or PBM to be experimental or not medically necessary. The IR process allows members the opportunity to have an independent consultant review their grievance to determine if benefits are payable.

Members must pay a $25 fee to request an IR and the IRO's decision is binding on both the plan or PBM and the member. Plans are required to notify members of their IR rights in all applicable grievance decision letters and are required to notify ETF when a member requests an IR (including providing ETF with notification of the outcome of the review when it is complete).

The Quality Assurance Services Bureau is responsible for ongoing education of members regarding the IR process. When the Department processes a new health insurance complaint, it is reviewed by an ombudsperson, and if appropriate, the member is contacted and educated

about the advantages and disadvantages of requesting an IR. The Department also monitors health plan grievance decision letters to ensure that members are given their IR rights when applicable.

In 2004, ETF was notified of 13 requests for independent reviews by state group health insurance program members. Of the 13 reviews requested, six (46%) of the reviews resulted in favorable resolutions for the member. Four of the reviews (31%) upheld the original plan decision, and one (8%) request was declined by the IRO.

The number of IR requests reported has continued to be low in comparison with the total number of medical necessity or experimental treatment denials, indicating that only a small percentage of members entitled to an IR elect to take advantage of this option. The Department will continue to work with plans to ensure compliance with the contract requirement of providing IR language in grievance decision letters. In addition, the Department will continue to ensure that plans comply with the contractual requirement of reporting all IR requests made by our members to ETF.

The attached charts summarize 2004 grievance data in greater detail. Quality Assurance Services Bureau staff will be available at the meeting to answer questions. Thank you.

Attachments