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CORRESPONDENCE MEMORANDUM

DATE: May 27, 2007

TO: Group Insurance Board

FROM: Steve Hurley, Director, Quality Assurance Services Bureau
Christina Keeley, Ombudsperson, Quality Assurance Services Bureau
Liz Doss-Anderson, Ombudsperson, Quality Assurance Services Bureau

SUBJECT: 2007 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 trends within the health insurance and pharmacy benefit manager (PBM) programs that warrant attention by the Department. A summary chart will also be included in the Report Card section of the *2009 It's Your Choice* booklet.

I. 2007 Grievance Report for State of Wisconsin and Local Employees

Below is a summary of annual grievance data provided to the Department of Employee Trust Funds (ETF) by all plans participating in the Group Health Insurance Program for State of Wisconsin (State) and Wisconsin Public Employees (WPE). This report includes grievance data for Navitus, which administers pharmacy benefits for all members excluding WPE Medicare-eligible annuitants. WPE Medicare-eligible annuitants are covered under Medicare D and their pharmacy benefit is administered by DeancareRx.

The report was compiled by reviewing each plan's annual grievance report. Grievance reports are submitted to ETF by the plans every March. A grievance is a written request to the plan by, or on behalf of, a member expressing dissatisfaction with a plan decision pertaining to a benefit denial or the provision of services under the contract. Highlights of the data include:

- Health plans reported 1,154 grievances for 2007, compared to 956 in 2006.

  Humana Eastern had the highest percentage of grievances among all health plans participating in the Group Health Insurance Program, with over 21% of all grievances reported, while holding only 6.79% of the total health insurance contracts.

  While grievances increased overall, Navitus Health Solutions has experienced a decrease in grievances each year since the PBM program began in 2004.

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

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Signature Date

Board	Mtg Date	Item #
GIB	06/10/2008	6

- In 2007, 662 (57%) of the 1,154 health plan grievances were either partly or fully overturned in favor of the member. Two plans had overturn rates greater than 80%: WPS Patient Choice Plan 2 had only one grievance, which was overturned; Humana had 251 grievances and 215 resulted in compromise or overturn.

  Moderate overturn rates demonstrate the benefit to members of utilizing the plan grievance process. However, very high overturn rates indicate a need for the plan to examine their claims payment policies and processes as well as make a concerted effort to ensure that Uniform Benefits are consistently interpreted and applied. If a plan overturns the majority of the grievances filed, the majority of the claims denied were denied incorrectly.

- The Emergency Room (ER) Services category for Humana Eastern and Humana Western is once again significantly higher than other plans. Humana reported 92 of the 106 emergency room service grievances reported to ETF by all health plans. Historically, Humana has experienced high overturn rates in this category, with 98% overturned in 2006 and 100% overturned in 2007.

  ETF staff and Humana representatives have had several discussions regarding the ER services grievance category. Humana reported a change effective mid-2006 to its ER services claims review process that permitted regional medical directors to authorize payments without sending the matter to formal grievance. However, this change did not subsequently reduce Humana's ER grievance totals. In 2007, Humana reported the mid-year discontinuation of its pend-and-review process for ER service claims coming from the state group. This change did not reduce ER grievances for 2007, but the first quarter of 2008 shows greatly reduced ER grievances. Humana reports that it has had only one ER grievance in the first quarter of 2008. The decrease in ER grievances for the first quarter of 2008 is encouraging. ETF staff will continue to monitor the ER category numbers for the remainder of 2008 and will continue to work with Humana representatives to resolve this matter.

- The total number of PBM grievances for 2007 was 173, down from 248 grievances reported in 2006 and from 315 grievances reported in 2005. The overturn rate for PBM grievances in 2007 was 29%. The majority of PBM grievances related to denials of copayment reductions (37%), followed by denial of non-covered drugs (31.8%).

  The continued decrease in the number of PBM grievances is an encouraging outcome and likely indicates that members are accustomed to the PBM structure and level of benefits. Navitus Health Solutions, has been administering this benefit since its inception in 2004 and has gained proficiency in understanding and consistently applying our benefits. Navitus proactively assists our members in maximizing savings through formulary compliance and use of cost-saving programs, such as mail order and tablet splitting.

- Two plans submitted relatively high numbers of grievances in the “other” category. The total number of grievances reported in this category for all plans was 160. Humana Eastern and Western combined reported 72 “other” and UnitedHealthcare NW and SE combined reported 54. Together Humana and UnitedHealthcare accounted for nearly 80% of all grievances in the “other” category.

ETF discourages plans from using the "other" category unless all other categories are inappropriate. ETF will continue to work with Humana and UnitedHealthcare to address what we consider to be an overuse of this category.

II. 2007 ETF Independent Review Report

This report summarizes independent review (IR) requests by State Group Health Insurance Program members. Members who request IRs must have completed the plan grievance process and may have completed a portion of the administrative review process available within ETF.

To be eligible for a review through an independent review organization (IRO), a member must have an adverse determination (grievance decision) involving a medical judgment wherein the amount at issue is in excess of $274. Typically these are requests for out-of-network referrals or denials of a claim or service that the plan/PBM has deemed 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/PBM and the member.

The Quality Assurance Services Bureau is responsible for educating members about 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 informed 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.

For 2007, plans reported receiving 20 requests for independent reviews by Group Health Insurance Program members. The outcomes of the reviews were evenly split, with eight resulting in the plan decision being upheld and eight resulting in the plan decision being overturned. Two reviews were declined by the review organization.

Health plans are required to report member requests for IR to ETF at the time the request is made. This year, only 11 of the 20 IR requests made by members were reported timely to ETF by health plans. The balance was reported in the health plans' annual report to ETF. Plans that failed to report IRs to ETF were CompcareBlue, Gundersen Lutheran Health Plan, Health Tradition, Humana, Physicians Plus, UnitedHealthcare and Unity Health Plan. The Quality Assurance Services Bureau addressed this issue with all health plans at the plan meeting held on April 29, 2008.

As in past years, the number of reported IR requests remains low in comparison with the total number of medical necessity or experimental treatment denials made by plans at the grievance level, 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 contractual requirement of including IR language with the plan's grievance decision letters and in reporting all IR requests made by our members to ETF.

The attached charts provide detailed grievance data. Percentages in the attached charts are approximate due to rounding. Quality Assurance Services Bureau staff will be available at the meeting to answer questions.