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CORRESPONDENCE MEMORANDUM

DATE: May 13, 2011

TO: Group Insurance Board

FROM: Christina Keeley, Ombudsperson
Liz Doss-Anderson, Ombudsperson
Vickie Baker, Ombudsperson
Office of Communications and Legislation

SUBJECT: 2010 Health Plan and Pharmacy Benefit Manager (PBM) Grievance and Independent Review Report

This memo is for informational purposes only. No Board action is required.

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 of this information will also be included in the 2012 *It's Your Choice* booklet.

I. 2010 Grievances

Below is a summary of annual grievance data provided to the Department of Employee Trust Funds (ETF) by all plans participating in the State of Wisconsin Group Health Insurance Program (State) and Wisconsin Public Employers Group Health Insurance Program (WPE). This report includes grievance data for Navitus Health Solutions, the PBM for all members excluding WPE Medicare-eligible annuitants. WPE Medicare-eligible annuitants (approximately 1,900 members) are covered under Medicare D and their pharmacy benefits are administered by DeancareRx.

This summary was compiled by reviewing each plan's annual grievance report provided to ETF every March. A grievance is a written request to the plan – by (or on behalf of) a member – expressing dissatisfaction with a plan decision about a benefit denial or the provision of services under the contract. Highlights of the data include:

- While overall the health insurance program experienced only a slight increase from 918 grievances in 2009 to 937 in 2010 (and 9 plans experienced a decrease in grievances); several health plans experienced fairly significant increases. Health Tradition Health Plan and Anthem Southeast increased in 2010. **See Attachment B.**

Reviewed and approved by Shawn Smith, Office of Communications and Legislation.
Shawn Smith — Signature
5/19/11 — Date

Board	Mtg Date	Item #
GIB	6.7.11	10Iii

- The program-wide average ratio of grievances filed compared to covered individuals (number of grievances per 100 members) is a low 0.4. Two plans have grievance ratios nearly tenfold that average. Anthem Northwest had a 3.3 ratio, and Humana Medicare PFFS had a 3.0 ratio. **See Attachment B.**

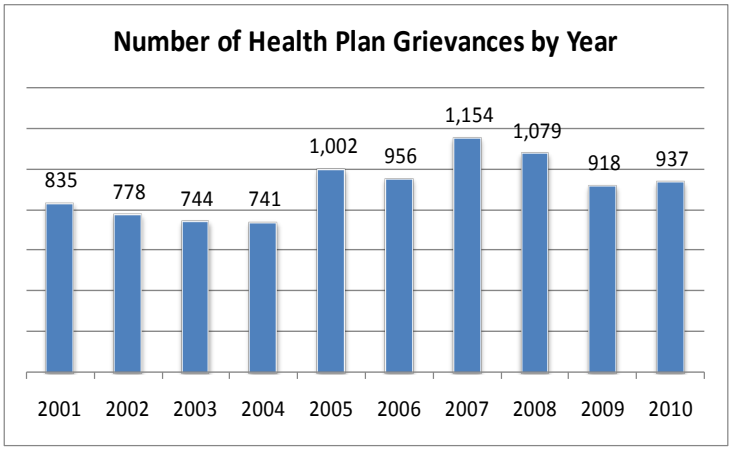
- The most common type of grievance was *non-covered benefit* at 276, 29% of all grievances. Both *prior authorization* denials and problems with *plan service/administration* had 153 grievances. Ombudsperson Services will continue to provide outreach and education to members regarding covered health insurance benefits and how best to work with their health plan to access care and better understand the services available from the health plans. **See Attachment D.**

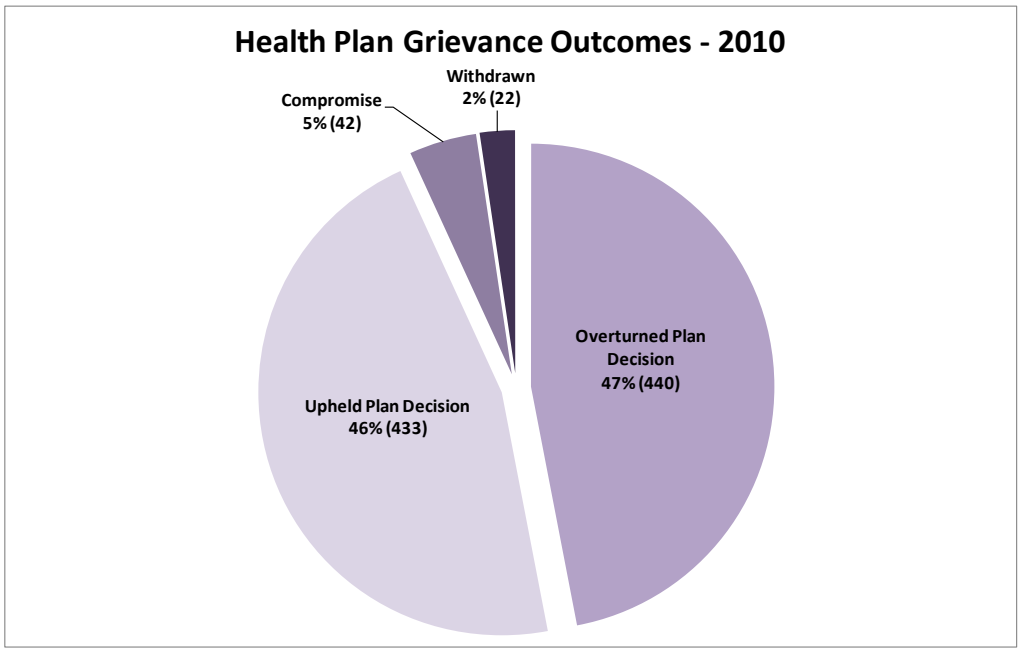
- Navitus, which administers the pharmacy benefits for approximately 236,000 members, received 86 grievances in 2010; 141 were received in 2009, a decrease of 24%. The two most common types of grievances were *denied co-payment reduction requests* and *requests for prior authorization*. **See Attachment A.**

- Humana Eastern, Western, and the Humana Medicare PFFS plan account for a combined total of 25.2% of all grievances filed. Department staff will work with Humana to find opportunities to improve service to members and ensure members have opportunities to resolve health plan issues informally if possible.

- 51% of all grievances reviewed by the health plans were overturned in favor of the member, including four health plans that had overturn rates of 85% or greater. **See page 4 and Attachment D.**

  Moderate favorable outcome rates demonstrate the value of utilizing the plan grievance process. However, when there are high rates of favorable outcomes with a high number of grievances, it is reasonable to conclude the majority of those initial denials were incorrect. This may indicate a need to examine the plan's benefits administration practices. High overturn rates coupled with a low number of overall grievances is not a reliable indicator of incorrect denials. Ombudsperson Services will develop a strategy for working more closely with the Division of Insurance Services and the plans that have an inordinate number of grievances or appear to have a pattern of excessive denials.





II. 2010 Independent Reviews

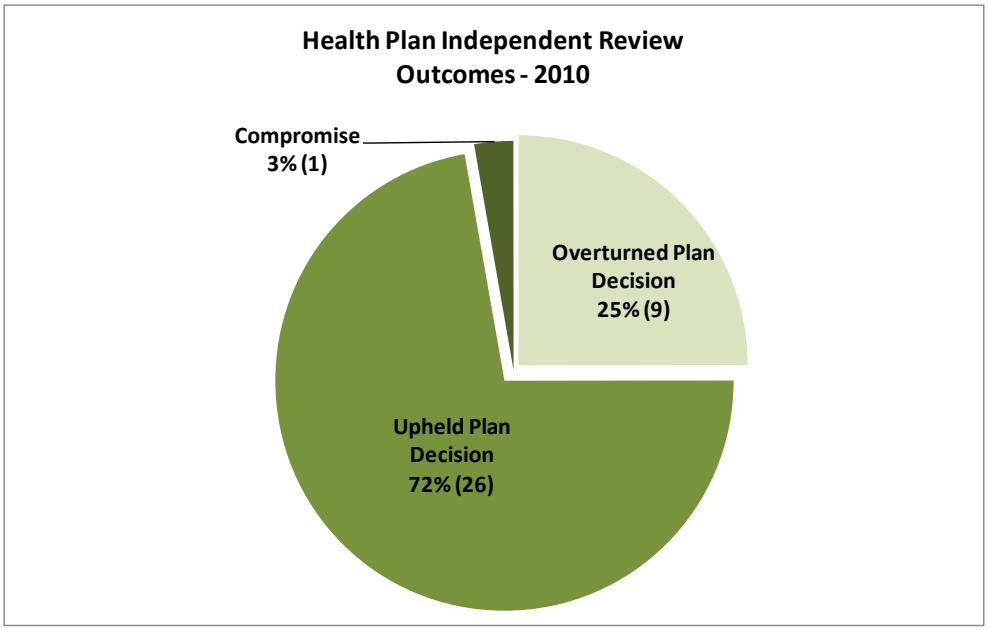
This report summarizes Independent Review (IR) requests by State Group Health Insurance Program members. Members who request IRs must have completed the plan grievance process and may have completed a portion of the administrative review process available within ETF.

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 where the amount at issue is in excess of $296. Typically, these are denied requests for out-of-network referrals or denials of a claim or service that the plan (or PBM) has deemed 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. The IRO's decision is binding on both the plan and the member. Therefore, once an IRO decision has been made, the member no longer has rights to an administrative review through ETF.

Ombudsperson Services is responsible for educating members about the IR process. When the Department processes a new health insurance complaint, an ombudsperson reviews it and, if appropriate, contacts the member to educate them about the IR option. We also monitor health plan grievance decisions. In one case, multiple issues were involved and the review resulted in a compromise.

For 2010, plans reported receiving 36 requests for independent reviews by Group Health Insurance Program members. In 9 cases, the IRO overturned the plan's original decision, while in 26 cases the IRO upheld the plan's original decision. In one case, multiple issues

were involved and the review resulted in a compromise.



Health plans are required to report member requests for IR to ETF at the time the request is made. This allows Ombudsperson Services the opportunity to notify the member of their loss of ETF administrative review rights. This year, there were several health plans with inconsistencies in the reporting of both requests for IR and/or the outcomes of the reviews. In addition, the number of reported IR requests remains low, when compared to the total number of grievance decisions that were eligible for IR. This indicates 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 revise plan reporting methods to ensure compliance with the contractual requirements of including IR language with the plan's grievance decision letters and timely reporting of all IR requests and IR outcomes to ETF.

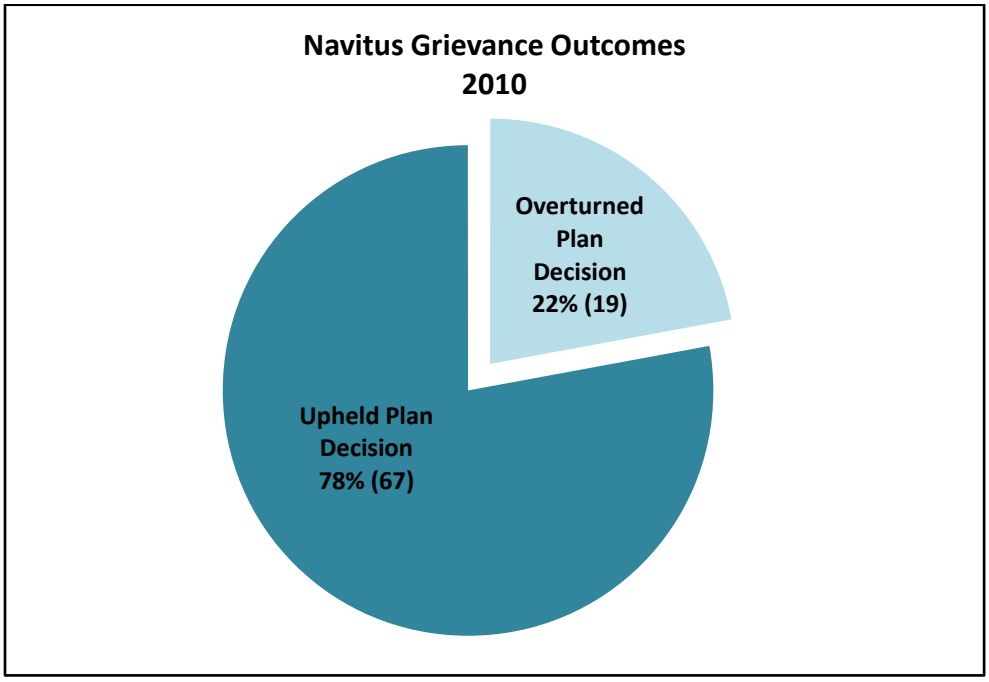
The attached charts provide more detailed information on grievances and outcomes. Percentages in the attached charts are approximate due to rounding.

Ombudsperson Services staff will be available at the meeting to answer questions.

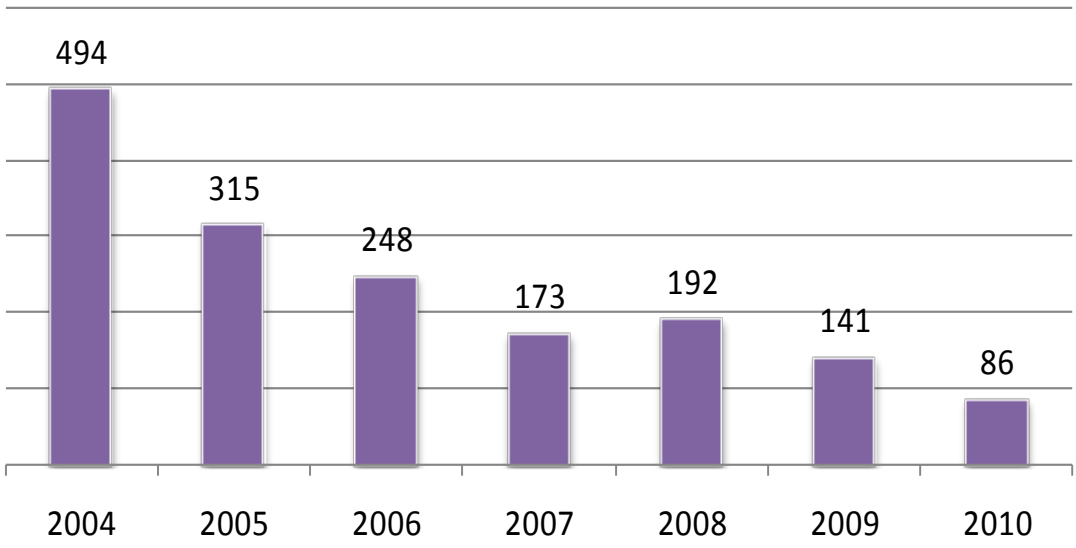
Attachments

Pharmacy Benefit Manager Grievances – 2010

Grievance Category	Number	Percent
Prior Authorization	20	23%
Non-covered Drug	14	17%
Not Medically Necessary	0	0%
Experimental	2	2%
Copayment Reduction	46	53%
Quantity Limit	4	5%
Reimbursement Request	0	0%
Other (Non-par Pharmacy)	0	0%
Total Grievances Received	86	100%



Attachment A



Attachment B

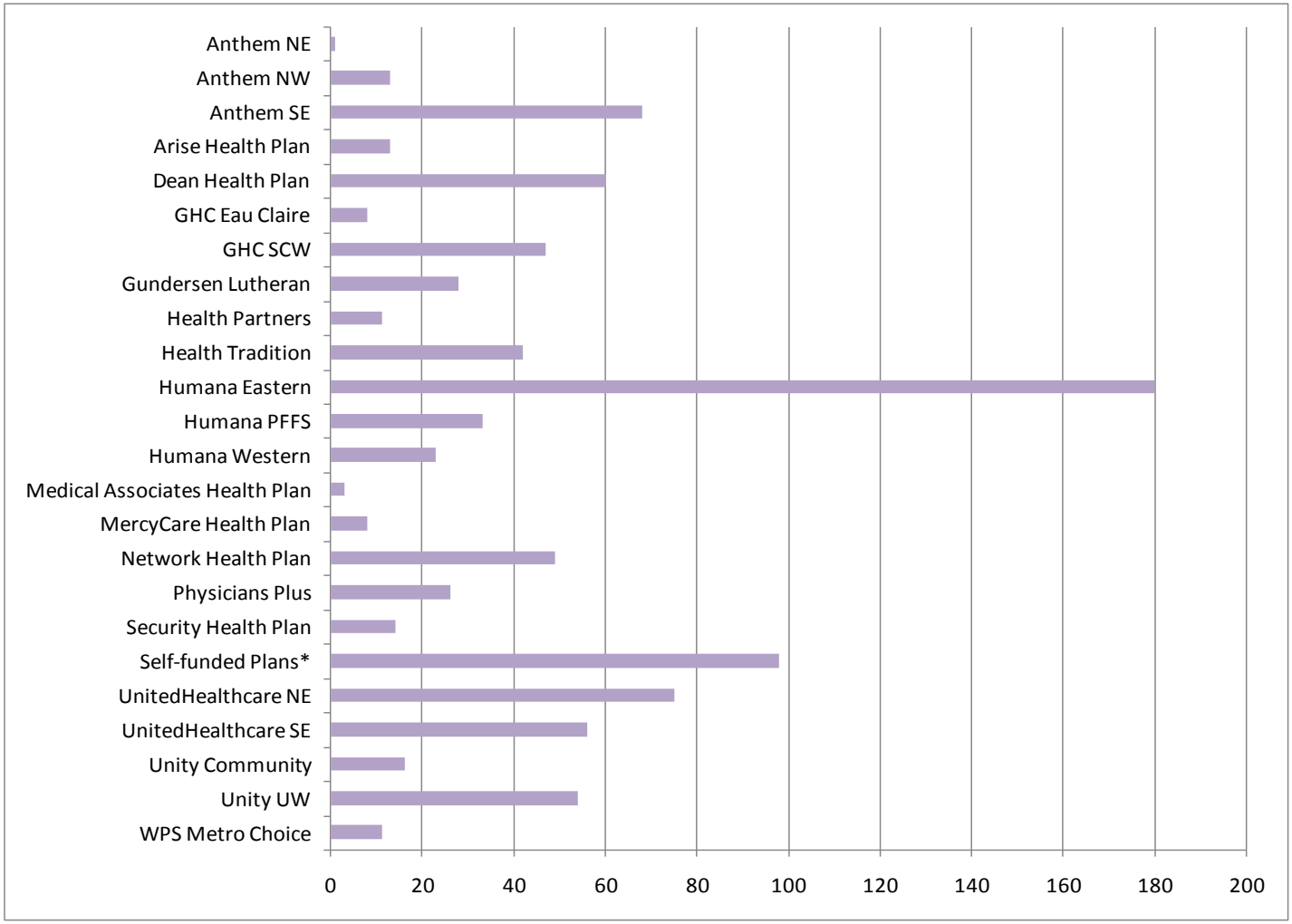
Grievances Filed by Health Plan
2008-2010

Health Plan Name	Grievances 2008	Grievances 2009	Grievances 2010	Net Change (2009 to 2010)	Grievances per 100 Members
Anthem NE*	NA	1	1	0	0.5
Anthem NW	44	29	13	-16	3.3
Anthem SE	59	56	68	12	1.4
Arise Health Plan	11	15	13	-2	0.5
Dean Health Plan	111	91	60	-31	0.1
GHC Eau Claire	17	12	8	-4	0.1
GHC South Central Wisconsin	21	39	47	8	0.3
Gundersen Lutheran	25	17	28	11	0.4
Health Partners**	NA	NA	11	NA	1.0
Health Tradition	14	23	42	19	0.7
Humana Eastern	192	172	180	8	1.0
Humana PFFS***	11	26	33	7	3.0
Humana Western	53	13	23	10	1.8
Medical Associates Health Plan	2	1	3	2	0.2
MercyCare Health Plan	8	8	8	0	0.4
Network Health Plan	54	49	49	0	0.4
Physicians Plus	20	22	26	4	0.1
Security Health Plan	25	15	14	-1	0.2
Self-funded Plans****	105	104	98	-6	0.7
UnitedHealthcare NE	117	88	75	-13	0.7
UnitedHealthcare SE	68	45	56	11	0.7
Unity Community	19	25	16	-9	0.2
Unity UW Health	79	54	54	0	0.2
WPS Patient Choice	24	13	11	-2	0.9
Grievance Totals (Health)	**1,079**	**918**	**937**	**19**	**0.4**

**Anthem NE was first introduced to ETF members for coverage effective January 1, 2009.*
***Health Partners was first introduced to ETF members for coverage effective January 1, 2010.*
****Self-funded Plans include: Standard Plan; Medicare Plus $1,000,000; Local Annuitant Health Plan; and State Maintenance*
Plan (all administered by WPS Health Insurance)

Attachment C

Grievances Filed by Health Plan
2010



**Self-funded Plans include: Standard Plan; Medicare Plus $1,000,000; Local Annuitant Health Plan; and State Maintenance Plan (all administered by WPS Health Insurance)*

Attachment D

2010 Health Plan Grievances by Type and Outcome

Plan Name	Access to Care	Continuity of Care	Drug & Drug Formulary	Emergency Services	Experimental Treatment	Prior Authorization	Non-Covered Benefit	Not Medically Necessary	Other	Plan Administration	Plan Providers	Request for Referral	Total	% of All Grievances	Approved	Denied	Compromise	Withdrawn	% with Favorable Outcome (approval or compromise)
Anthem NE	0	0	0	0	0	0	1	0	0	0	0	0	**1**	0.1%	0	1	0	0	0.0%
Anthem NW	0	0	0	0	1	0	1	1	1	6	0	3	**13**	1.4%	6	3	4	0	76.9%
Anthem SE	0	0	1	7	10	0	9	12	1	25	1	2	**68**	7.3%	18	35	15	0	48.5%
Arise Health Plan	0	0	0	0	0	8	2	3	0	0	0	0	**13**	1.4%	6	7	0	0	46.2%
Dean Health Plan	0	1	0	0	2	20	18	7	0	2	0	10	**60**	6.4%	36	21	2	1	63.3%
GHC Eau Claire	0	0	0	0	0	0	3	0	2	0	2	1	**8**	0.9%	3	3	0	2	37.5%
GHC SCW	0	0	0	17	2	1	9	3	0	2	13	0	**47**	5.0%	14	31	2	0	34.0%
Gundersen Lutheran	0	0	0	0	0	4	19	1	0	2	0	2	**28**	3.0%	15	13	0	0	53.6%
Health Partners	3	1	0	0	0	0	1	1	0	0	0	5	**11**	1.2%	6	4	0	1	54.5%
Health Tradition	0	0	0	5	0	7	14	12	0	1	0	3	**42**	4.5%	20	16	0	6	47.6%
Humana Eastern	1	0	2	10	8	8	93	21	10	19	0	8	**180**	19.2%	100	74	5	1	58.3%
Humana Western	0	0	0	0	0	11	6	1	0	3	0	2	**23**	2.5%	15	6	2	0	73.9%
Humana PFFS	0	0	0	0	0	0	0	8	0	25	0	0	**33**	3.5%	23	9	1	0	72.7%
Medical Associates Health Plan	0	0	0	0	0	1	0	1	0	0	1	0	**3**	0.3%	0	3	0	0	0.0%
MercyCare Health Plan	0	0	0	0	0	2	1	0	0	0	0	5	**8**	0.9%	5	2	0	1	62.5%
Network Health Plan	0	1	0	0	6	24	8	6	0	1	3	0	**49**	5.2%	28	20	0	1	57.1%
Physicians Plus	0	0	0	4	0	10	9	0	0	2	1	0	**26**	2.8%	8	17	0	1	30.8%
Security Health Plan	0	0	0	0	1	4	2	1	0	3	0	3	**14**	1.5%	7	6	0	1	50.0%
Self-funded Plans*	0	0	0	0	12	2	35	41	4	2	2	0	**98**	10.5%	32	58	1	7	33.7%
UnitedHealthcare NE	13	0	0	1	16	0	12	0	0	30	3	0	**75**	8.0%	42	32	1	0	57.3%
UnitedHealthcare SE	8	0	0	0	6	0	13	0	0	26	3	0	**56**	6.0%	35	19	2	0	66.1%
Unity Community	0	0	0	0	0	10	5	0	0	1	0	0	**16**	1.7%	1	14	1	0	12.5%
Unity UW	0	0	0	0	1	41	11	0	0	1	0	0	**54**	5.8%	12	37	5	0	31.5%
WPS Metro Choice	0	0	0	0	1	0	4	4	0	2	0	0	**11**	1.2%	8	2	1	0	81.8%
Total	**25**	**3**	**3**	**44**	**66**	**153**	**276**	**123**	**18**	**153**	**29**	**44**	**937**	100.0%	**440**	**433**	**42**	**22**	**51.4%**
% of Total Grievances	0.7%	0.1%	0.0%	5.1%	7.8%	12.7%	28.6%	10.6%	9.0%	12.7%	8.0%	4.6%	100.0%		46.8%	43.1%	7.7%	2.3%	

Attachment E