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CORRESPONDENCE MEMORANDUM

DATE: April 27, 2012

TO: Group Insurance Board

FROM: Dan Hayes, Attorney/Supervisor
Liz Doss-Anderson, Ombudsperson
Vickie Baker, Ombudsperson

SUBJECT: 2011 Health Plan and Pharmacy Benefit Manager 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 of Employee Trust Funds (ETF). A summary of this information will also be included in the 2013 *It's Your Choice* booklet.

2011 PLAN GRIEVANCES

Below is a summary of annual grievance data provided to ETF by all plans participating in the State of Wisconsin Group Health Insurance Program and the Wisconsin Public Employers Health Insurance Program (WPE). This report includes grievance data for Navitus Health Solutions, the pharmacy benefits manager (PBM) for all group health insurance members except WPE Medicare-eligible annuitants. WPE Medicare-eligible annuitants (approximately 1,900 members) were covered under a Medicare Part D plan administered by DeanCareRx PDP in 2011.

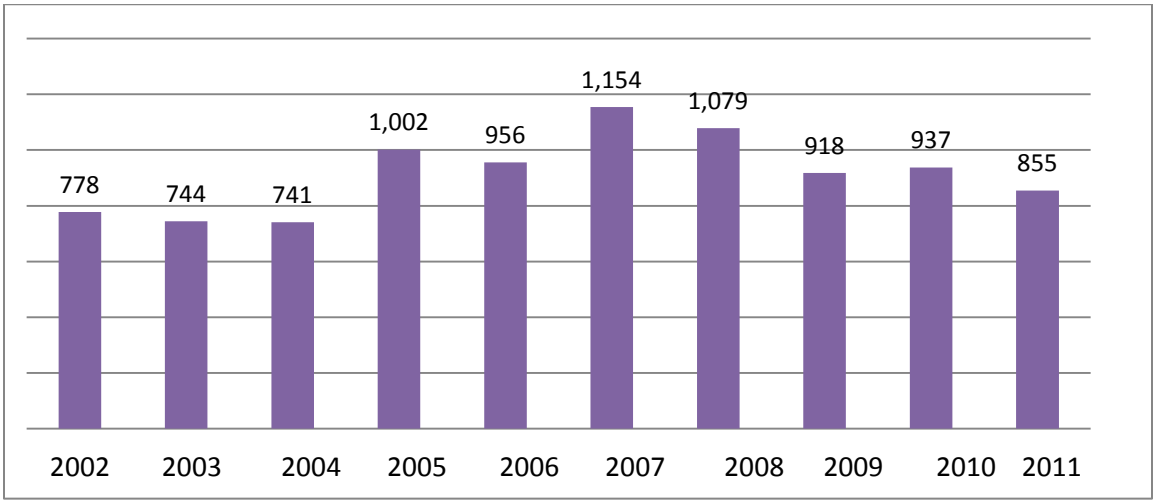
This summary was compiled by reviewing each plan's annual grievance report to ETF. A grievance is a written request to the plan by, or on behalf of, a member expressing dissatisfaction with a plan decision about a benefit denial or the provision of services under the contract. Highlights of the data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

- The health insurance program experienced an overall decrease in grievances, from 937 in 2010 to 855 in 2011, the lowest number of grievances since 2004.

Reviewed and approved by David Nispel, General Counsel, Legal Services
David H. Nispel — Signature
5/4/12 — Date

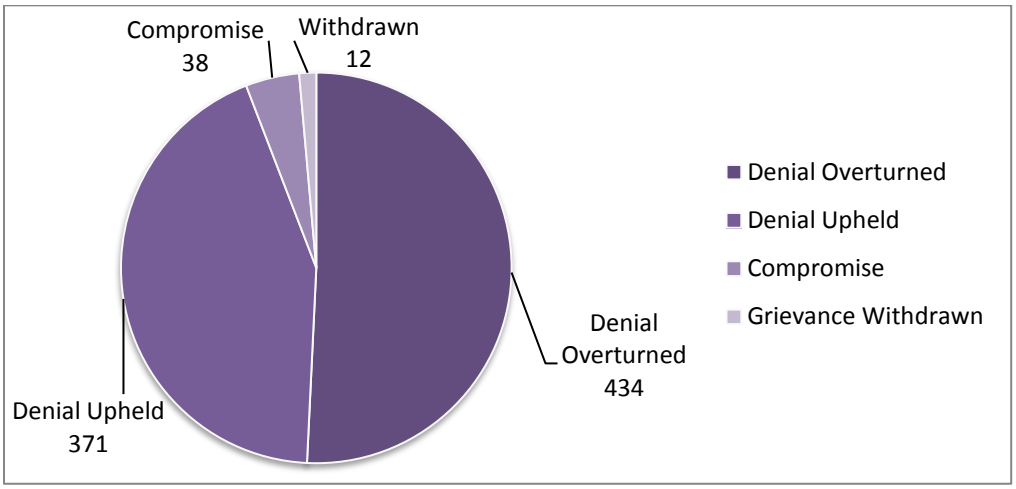
Board	Mtg Date	Item #
GIB	5.22.12	7B

Number of Health Plan Grievances by Year – 2011



- 434 (51%) of the 855 grievances filed were overturned in favor of the member and an additional 38 resulted in compromise settlements. The original plan decision was upheld 43% of the time. This favorable outcome rate demonstrates the value of utilizing the plan grievance process.

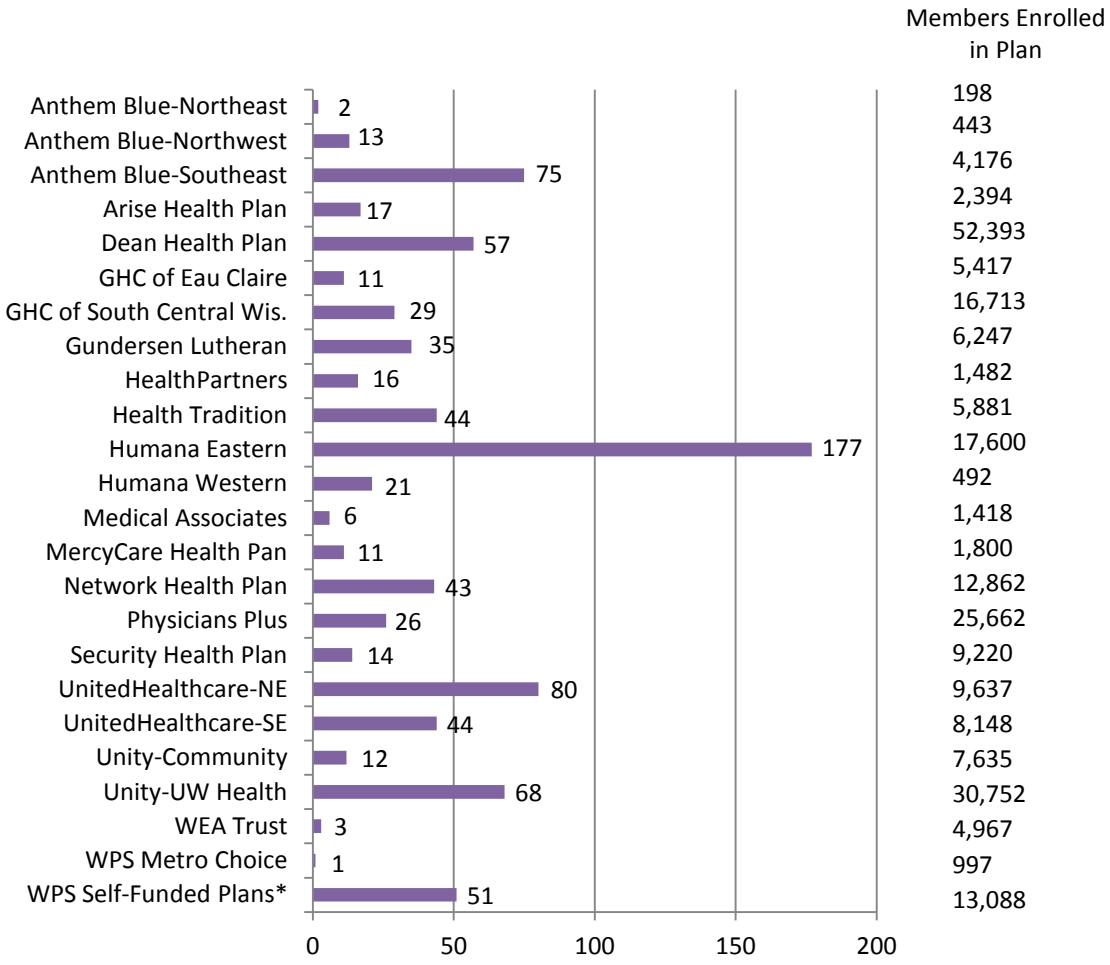
Grievance Outcomes – 2011



- Seven plans experienced a decrease in the number of grievances. The WPS-administered Standard Plan (and smaller self-funded plans) experienced the largest decrease, with 47 fewer grievances than in 2010, a 48% decrease. The WPS Metro Choice plan went from 11 grievances to 1. GHC-South Central

Wisconsin achieved a 38% decrease in grievances; Humana-Western's total was down by 36%. Most of the health plans that had more grievances in 2011 than in the previous year reported only minor increases.

GRIEVANCES BY HEALTH PLAN – 2011



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

- Humana Eastern again leads our plans in number of grievances filed, with 21% of the total for all plans. However, the number is a slight decrease from 2010. More recently, with the assignment of new Humana staff to work with Ombudsperson Services staff, some member complaints have been resolved quickly and we expect Humana's grievance numbers to decrease further in 2012.

- The most common type of grievance reported by health plans was for *health plan administration and service* and *non-covered benefit,* with 184 complaints in each category, or 43% of all grievances filed by ETF members. Historically, health plan administration and service has never accounted for the highest number of grievances. As in past years, *prior authorization* denials were significant with 165 grievances while *not medically necessary* denials resulted in 103 grievances.

  Ombudsperson Services staff will continue to work with members and plan contacts to resolve denials and other claim issues whenever possible. Staff will also continue educating members about their covered benefits.

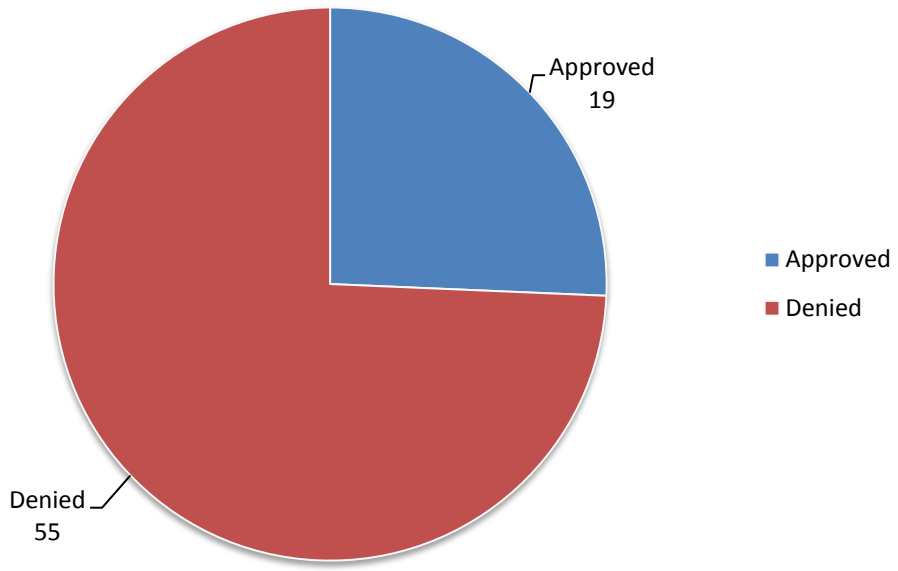
- Navitus, ETF's pharmacy benefits manager, received 72 grievances in 2011, continuing a downward trend for the PBM (86 in 2010 and 141 in 2009). To put this in perspective, more than 208,000 members filed claims for pharmacy benefits in 2011.

- For Navitus, the two most common types of grievances were denials of co-payment reductions and prior authorization requests. In 2011, Navitus resolved 74 grievances, including two carried over from 2010. The initial decision was upheld in 55 cases (74%) while there were 19 overturned denials (26%).

Navitus Grievances by Category - 2011

Copayment Reduction	36	50%
Prior Authorization Denial	17	24%
Non-covered Drug	8	11%
Quantity Limit	5	7%
Experimental	3	4%
Reimbursement Requests	3	4%

Navitus Grievance Outcomes – 2011



2011 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 some steps 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 was at least $295 in 2011. Typically, these are denials of a claim or service that the plan or PBM has deemed experimental or not medically necessary. This includes the denial of a request for a referral for out-of-network services because the clinical expertise of the out-of-network provider may be medically necessary for treatment of the insured's medical condition and that expertise is not available in the insurer's provider network.

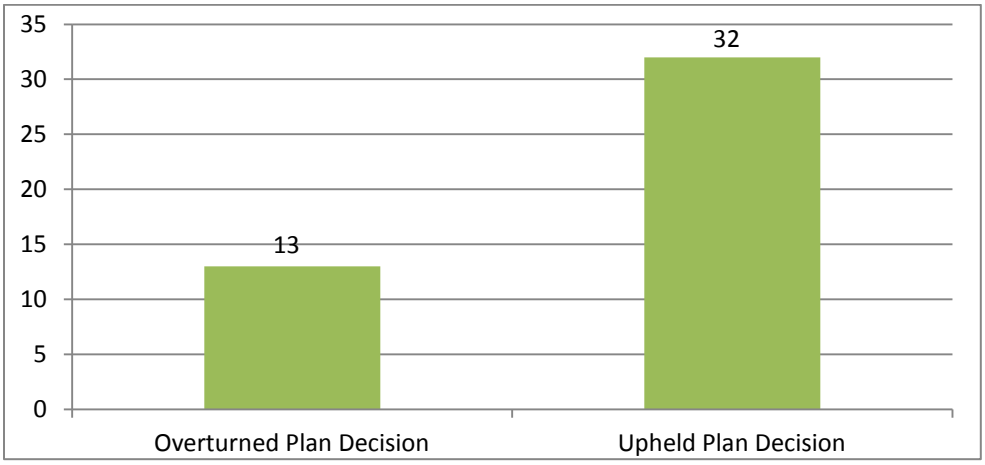
An IR may also be used: 1) whenever a health plan denies coverage for treatment on the basis of a pre-existing condition exclusion; and 2) if the insurer rescinds a health insurance policy or certificate. Rescission means that the insurer retroactively cancels a policy or modifies the terms of the policy because it maintains that a member did not answer the health questions on the application for insurance completely and accurately.

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 staff are responsible for educating members about the IR process and for making sure that proper IRO notice is given to a member when appropriate. When ETF processes a new health insurance complaint, an Ombudsperson reviews it and, if appropriate, contacts the member to educate them about the IR option.

Health plans reported receiving an increase in IRO filings for 2011, with 45 IROs filed compared to 36 in 2010, and 31 in 2009. In 2011, the IRO upheld the plan's grievance decision in 32 cases (71%), while in 13 cases (29%) the IRO overturned the plan's grievance decision. This is consistent with 2010, when nearly three-fourths of plan grievance decisions were upheld.

IRO OUTCOMES - 2011



RECENT CHANGES IN OMBUDSPERSON SERVICES

Ombudsperson Services became part of the Office of Legal Services in November 2011. With the recent addition of a third staff ombudsperson, we are now fully staffed. Long-time ETF employee Allen Angel transferred from the Division of Retirement Services to join veteran staff Liz Doss-Anderson and Vickie Baker. Attorney Dan Hayes supervises the Ombudsperson Services staff and ETF General Counsel David Nispel oversees all aspects of the Office of Legal Services.

Ombudsperson Services staff will be available at the Board meeting to answer questions you may have.

Grievances By Health Plan
2009-2011

HEALTH PLAN	2009 Grievances	2010 Grievances	2011 Grievances	Net Change (2010-2011)	Number of Members
Anthem Blue-Northeast	1	1	2	1	198
Anthem Blue-Northwest	29	13	13	0	443
Anthem Blue-Southeast	56	68	75	7	4,176
Arise Health Plan	15	13	17	4	2,394
Dean Health Plan	91	60	57	-3	52,393
GHC of Eau Claire	12	8	11	3	13,155
GHC of South Central Wisconsin	39	47	29	-18	16,713
Gundersen Lutheran Health Plan	17	28	35	7	6,247
HealthPartners	N/A	11	16	5	1,482
Health Tradition	23	42	44	2	5,881
Humana Eastern	192	180	177	-3	17,232
Humana Western	19	33	21	-12	1,096
Medical Associates Health Plan	1	3	6	3	1,418
MercyCare Health Plan	8	8	11	3	1,800
Network Health Plan	49	49	43	-6	12,862
Physicians Plus	22	26	26	0	25,662
Security Health Plan	15	14	14	0	9,220
UnitedHealthcare NE	88	75	80	5	9,637
UnitedHealthcare SE	45	56	44	-12	8,148
Unity-Community	25	16	12	-4	7,635
Unity -UW Health	54	54	67	13	30,752
WEA Trust	N/A	N/A	3	N/A	4,967
WPS Metro Choice	13	11	1	10	997
WPS Self-Funded Plans*	104	98	51	-47	14,085
TOTAL	**918**	**937**	**855**	**82**	**247,596**

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

Contracts and Members By Health Plan

Health Plan	2011 Contracts	2011 Members
ANTHEM BLUE-NORTHEAST	89	198
ANTHEM BLUE-NORTHWEST	249	443
ANTHEM BLUE-SOUTHEAST	1,952	4,176
ARISE HEALTH PLAN	1,031	2,394
DEAN HEALTH PLAN	22,956	52,393
GHC OF EAU CLAIRE	5,417	13,155
GHC OF SOUTH CENTRAL WISCONSIN	8,886	16,713
GUNDERSEN LUTHERAN HEALTH PLAN	2,586	6,247
HEALTH TRADITION	2,218	5,881
HEALTHPARTNERS	570	1,482
HUMANA EASTERN	7,600	17,232
HUMANA WESTERN	492	1,096
MEDICAL ASSOCIATES HEALTH PLAN	561	1,418
MERCYCARE HEALTH PLAN	690	1,800
NETWORK HEALTH PLAN	5,114	12,862
PHYSICIANS PLUS	11,785	25,662
SECURITY HEALTH PLAN	3,744	9,220
STATE MAINTENANCE PLAN	111	255
STATE MAINTENANCE PLAN (WPE)	64	171
STANDARD DANE PPP	1	4
STANDARD MILWAUKEE PPP	1	1
STANDARD PLAN	8,201	11,988
STANDARD PLAN DANE (WPE)	39	53
STANDARD PLAN MILWAUKEE (WPE)	90	133
STANDARD WAUKESHA (WPE)	16	22
STANDARD WISCONSIN (WPE)	79	116
UNITEDHEALTHCARE NE	3,971	9,637
UNITEDHEALTHCARE SE	3,179	8,148
UNITY-COMMUNITY	2,826	7,635
UNITY-UW HEALTH	13,855	30,752
WEA TRUST	1,884	4,967
WPS METRO CHOICE	448	997
LAHP-MED SUP-AGE 65-67	13	20
LAHP-MED SUP-AGE 68-69	16	21
LAHP-MED SUP-AGE 70-74	38	54
LAHP-MED SUP-AGE 75 AND OVER	186	237
LAHP PPP - UNDER 65 - NO MED	5	5
LAHP PPP - UNDER 65 - WITH MED	4	6
Total	**110,967**	**247,594**