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CORRESPONDENCE MEMORANDUM

DATE: April 25, 2013

TO: Group Insurance Board

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

SUBJECT: 2012 Health Plan and Pharmacy Benefit Manager Grievance and Independent Review Report

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

The information provided in this report is used to identify trends and areas of concern within the health insurance and pharmacy benefit manager (PBM) programs. A summary of this information will also be included in the 2014 *It's Your Choice* booklet.

I. 2012 Grievances

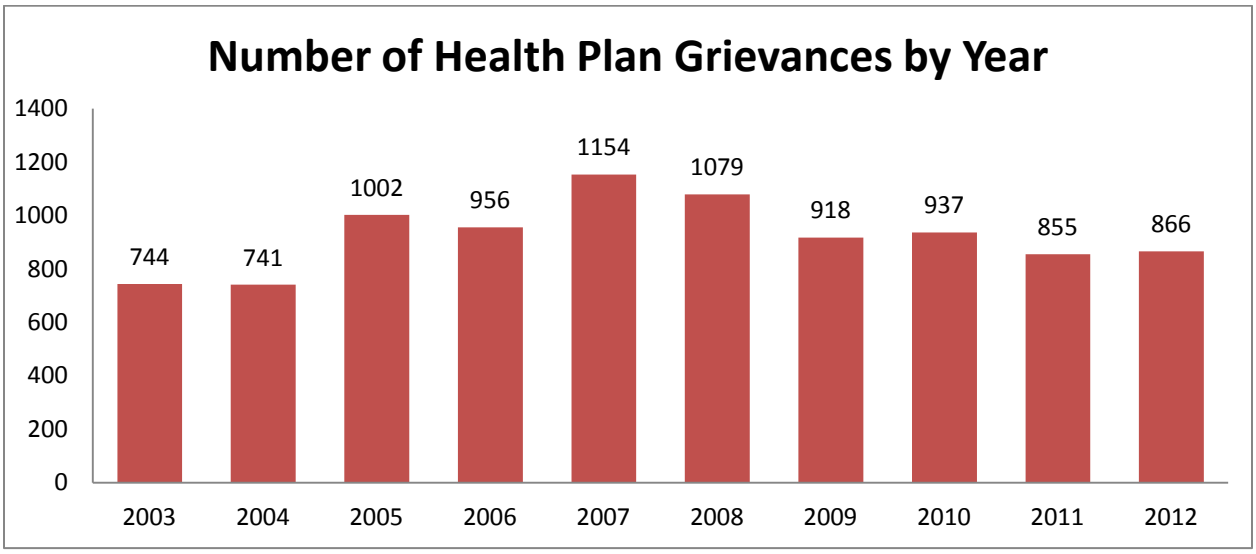
Below is a summary of annual grievance data provided to the Department of Employee Trust Funds (ETF) by all plans participating in the State of Wisconsin Group Health Insurance Program. This report also includes grievance data for Navitus Health Solutions, the pharmacy benefits manager (PBM) for all group health insurance members including those covered under the Navitus Medicare D Rx plan.

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

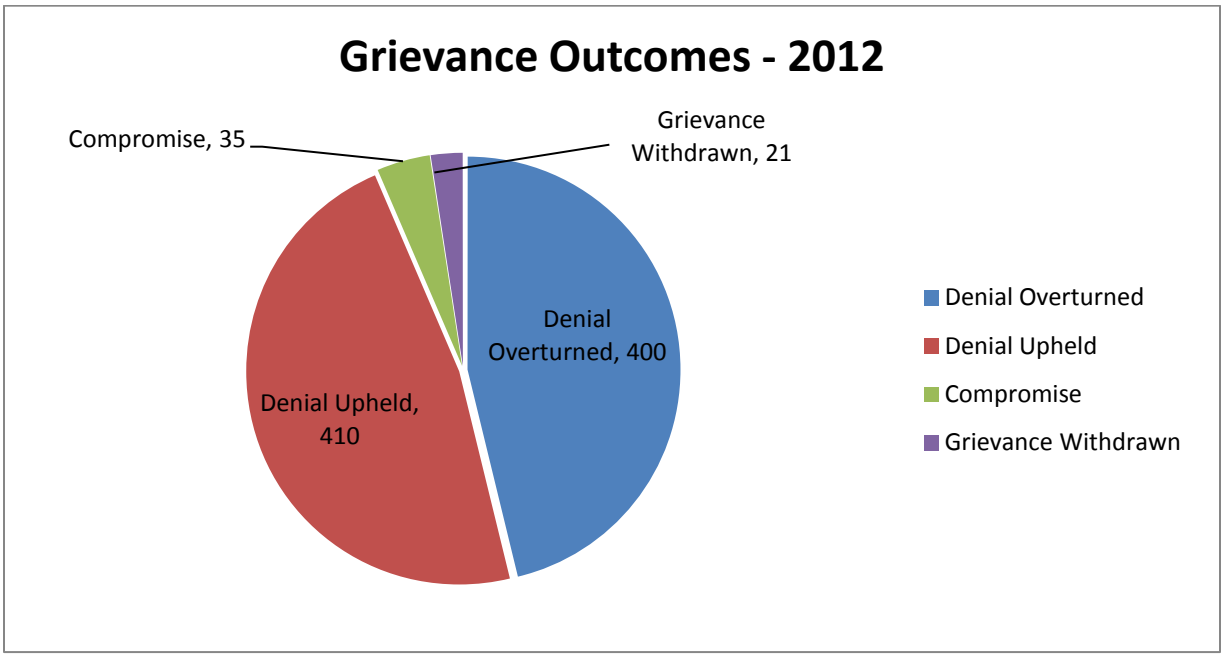
- The number of grievances experienced by the health insurance program was very stable from 2011 to 2012 with overall increase of 11 grievances from 855 in 2011 to 866 in 2012. This total was significantly lower than the six years prior to 2011.

Reviewed and approved by David Nispel, General Counsel, Legal Services
David H. Nispel
Electronically Signed 5/3/13

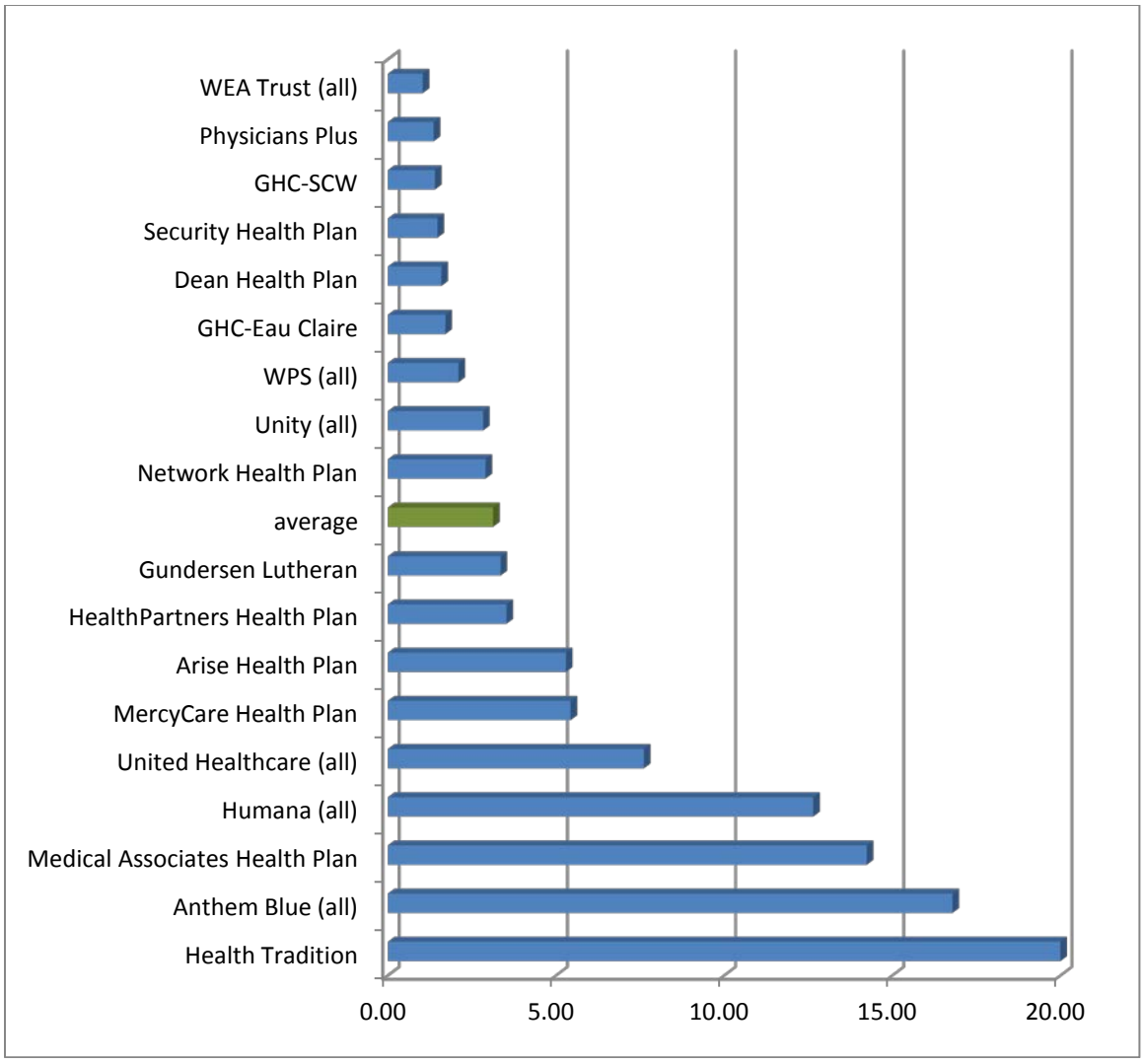
Board	Mtg Date	Item #
GIB	5.21.13	8G



- 400 (46%) of the 866 grievances filed were overturned in favor of the member and an additional 35 resulted in compromise settlements. The original plan decision was upheld 50% percent of the time. This favorable outcome rate demonstrates the value of utilizing the plan grievance process when appropriate.



GRIEVANCES BY HEALTH PLAN – 2012
(Number of Grievances per 1,000 members)



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

- Humana had the highest number of grievances filed with 202 or 23% of the total for all health plans. The next two highest were Unity with134 grievances and United Healthcare with 125 grievances.

- 13 plans experienced a decrease in grievances. Most health plans that experienced an increase in grievances in 2012 compared to 2011, reported only minor increases.

- Three grievances per 1,000 members was the average number of grievances across all plans.

- Again in 2012, the most common type of grievance related to *health plan administration* with 222 or 26% of all grievances filed. Grievances for *non-covered benefits* were a close second with a total of 209. It appears that members are becoming more active in their health care and are challenging more health plan decisions as they understand the complexity of their benefits. As in prior years, grievances related to denials of *prior-authorizations* were high with 182 filed, while *not medically necessary* denials remained consistent by generating 107 grievances.

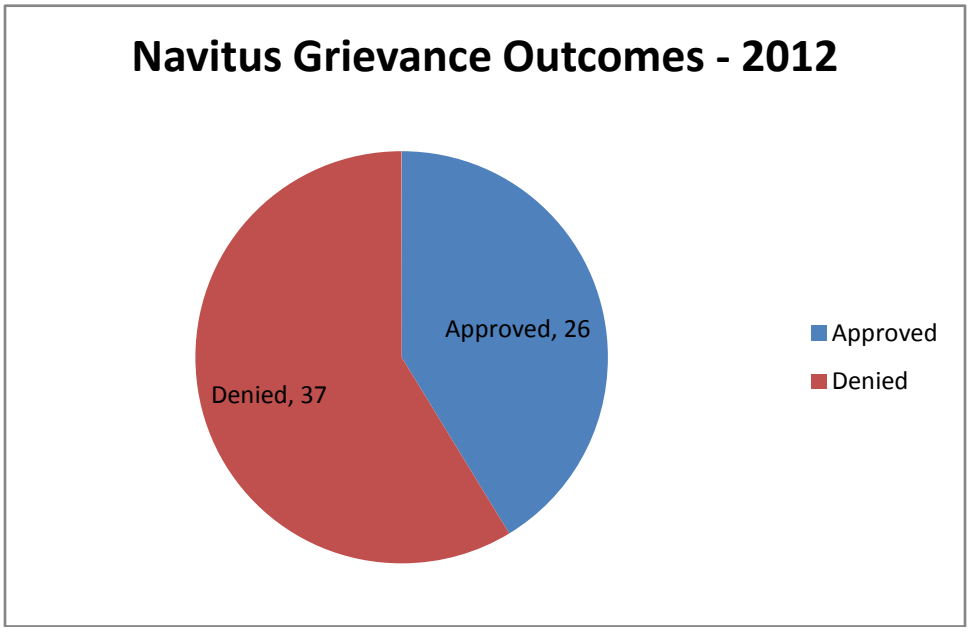
- Ombudsperson Services continues to work with members and our health plan contacts to resolve health insurance issues prior to grievance. We also continue to educate our members about their benefits whenever we make contact with them. In addition, we work with plans to assist the members in understanding their administrative appeal and independent review rights when applicable.

- Navitus, which administers the pharmacy benefit, received 53 grievances in 2012, continuing a downward trend for the PBM (72 in 2011 and 86 in 2010). To put this in perspective, over 202,000 members filed claims for pharmacy benefits in 2012.

- For Navitus, the two most common types of grievances were denials of copayment reductions and prior authorization requests. Regarding the 53 grievances in 2012, the initial decision was upheld in 37 cases (70%) and 16 were overturned (30%).

Navitus Grievances by Category - 2012

Copayment Reduction	20	38%
Prior Authorization Denial	16	30%
Non-covered Drug	10	19%
Reimbursement Requests	3	6%
Experimental	3	6%
Quantity Limit	1	1%



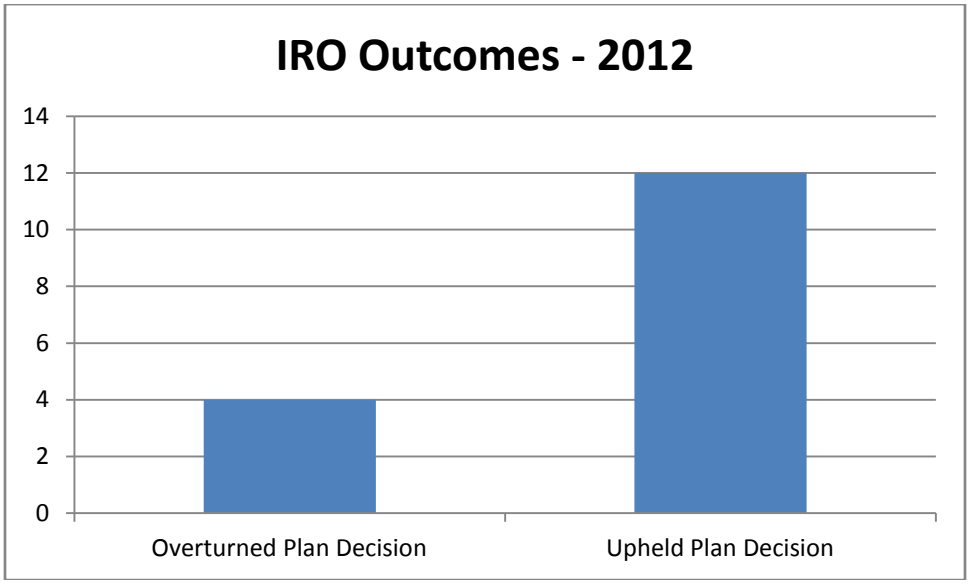
II. 2012 Independent Reviews

This report summarizes Independent Review (IR) requests by State Group Health Insurance Program members. Members who request IRs must have completed the health plan grievance process and may have completed some steps of the administrative review process offered by ETF. IRs are conducted by an Independent Review Organization (IRO).

To be eligible for a review through an IRO, a member must have an "adverse determination" (grievance denial) involving a medical judgment. Typically, these are denials of a claim or service that the plan or PBM has deemed experimental or not medically necessary. This includes denial for a referral to out-of-network services when a member believes an 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.

The IR process allows members to have an outside expert review their grievance and determine if benefits are payable. The IRO's decision is binding on both the plan and the member. As a result, once an IRO decision has been made, the member no longer has rights to an administrative review through ETF or the courts. 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 and process.

IR requests decreased significantly in 2012 with just 16 requests from members. In comparison, there were 45 IRs filed in 2011 and 36 in 2010. In 2012, the IRO upheld the plan's grievance decision in 12 cases (75%), while in 4 cases (25%) the IRO overturned the plan's decision. This is consistent with 2011 when 71% of plan grievance decisions were upheld.



Grievances by Health Plan
2010-2012

HEALTH PLAN	2010 Grievances	2011 Grievances	2012 Grievances	Net Change (2011-2012)	Number of Members
Anthem Blue-Northeast	1	2	3	+1	203
Anthem Blue-Northwest	13	13	13	-0-	359
Anthem Blue-Southeast	68	75	53	-22	3,547
Arise Health Plan	13	17	11	-6	2,077
Dean Health Plan	60	57	74	+17	46,399
GHC of Eau Claire	8	11	3	-8	1,752
GHC of South Central Wisconsin	47	29	23	-6	16,412
Gundersen Lutheran Health Plan	28	35	20	-15	5,967
HealthPartners Health Plan	11	16	19	+3	5,384
Health Tradition	42	44	27	-17	1,327
Humana Eastern	180	177	186	+9	15,024
Humana Western	33	21	16	-5	944
Medical Associates Health Plan	3	6	19	+13	1,334
MercyCare Health Plan	8	11	8	-2	1,472
Network Health Plan	49	43	36	-7	12,392
Physicians Plus	26	26	32	+6	23,485
Security Health Plan	14	14	12	-2	8,128
UnitedHealthcare NE	75	80	69	-11	8,228
UnitedHealthcare SE	56	44	56	+12	8,187
Unity-Community	16	12	21	+9	12,468
Unity-UW Health	54	67	113	+46	34,814
WEA Trust-East	N/A	3	19	+16	11,768
WEA Trust-Northwest	N/A	N/A	5	N/A	11,357
WPS Metro Choice	11	1	5	+4	856
WPS Self-Funded Plans	98	51	23	-28	12,471
TOTAL	**937**	**855**	**866**	**+11**	**246,355**

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Staff will be at the Board meeting to answer any questions.