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CORRESPONDENCE MEMORANDUM

DATE: April 25, 2014

TO: Group Insurance Board

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

SUBJECT: 2013 Health Plan 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 programs administered by the Department of Employee Trust Funds (ETF). A summary of this information will also be included in the 2015 *It's Your Choice Decision Guide* and online material.

2013 Health Plan Grievances

Below is a summary of the annual grievance data reported to ETF by all plans participating in the State of Wisconsin Group Health Insurance Program. This report also includes grievance data for Navitus Health Solutions (Navitus), the pharmacy benefits manager (PBM) for all members with pharmacy benefits through the program, including the Navitus Medicare D Rx plan.

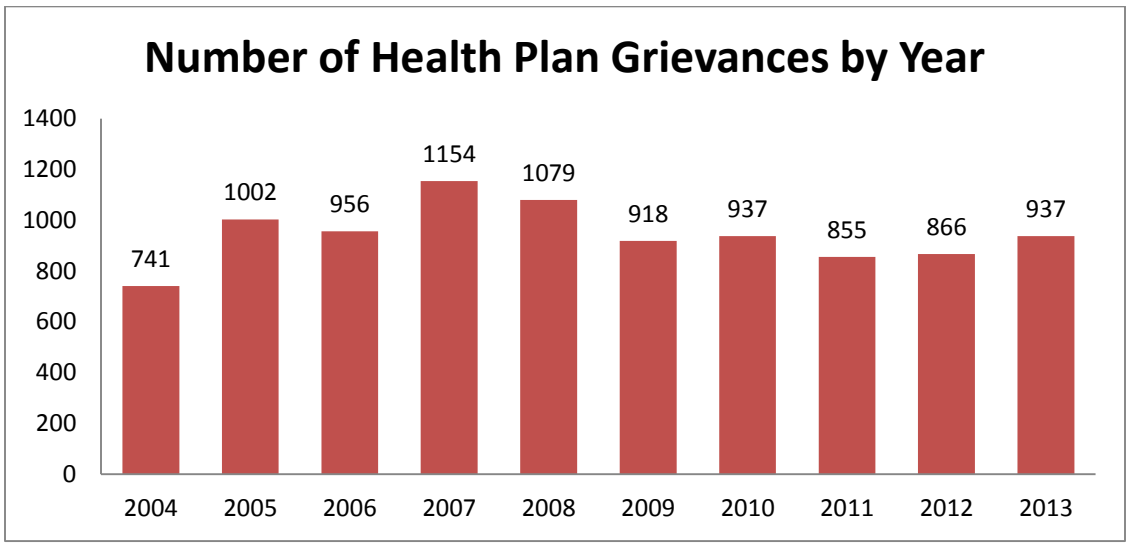
By contract, health plans are required to report any written grievance by a member to the plan expressing dissatisfaction with a plan decision related to a denial of benefits or the provision of services provided within the health insurance contract. Highlights of data submitted for 2013 include:

- The number of grievances reported by health plans increased from 866 in 2012 to 937 in 2013. This number is within the historical range in recent years (see chart on Page 2).

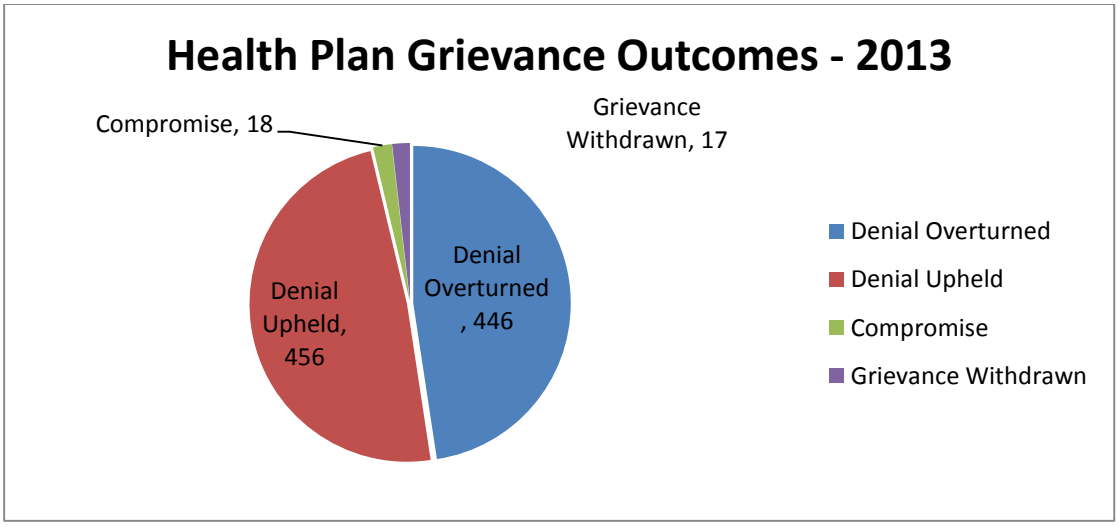
Reviewed and approved by David Nispel, General Counsel, Legal Services
David H. Nispel
Electronically Signed: 05/01/2014

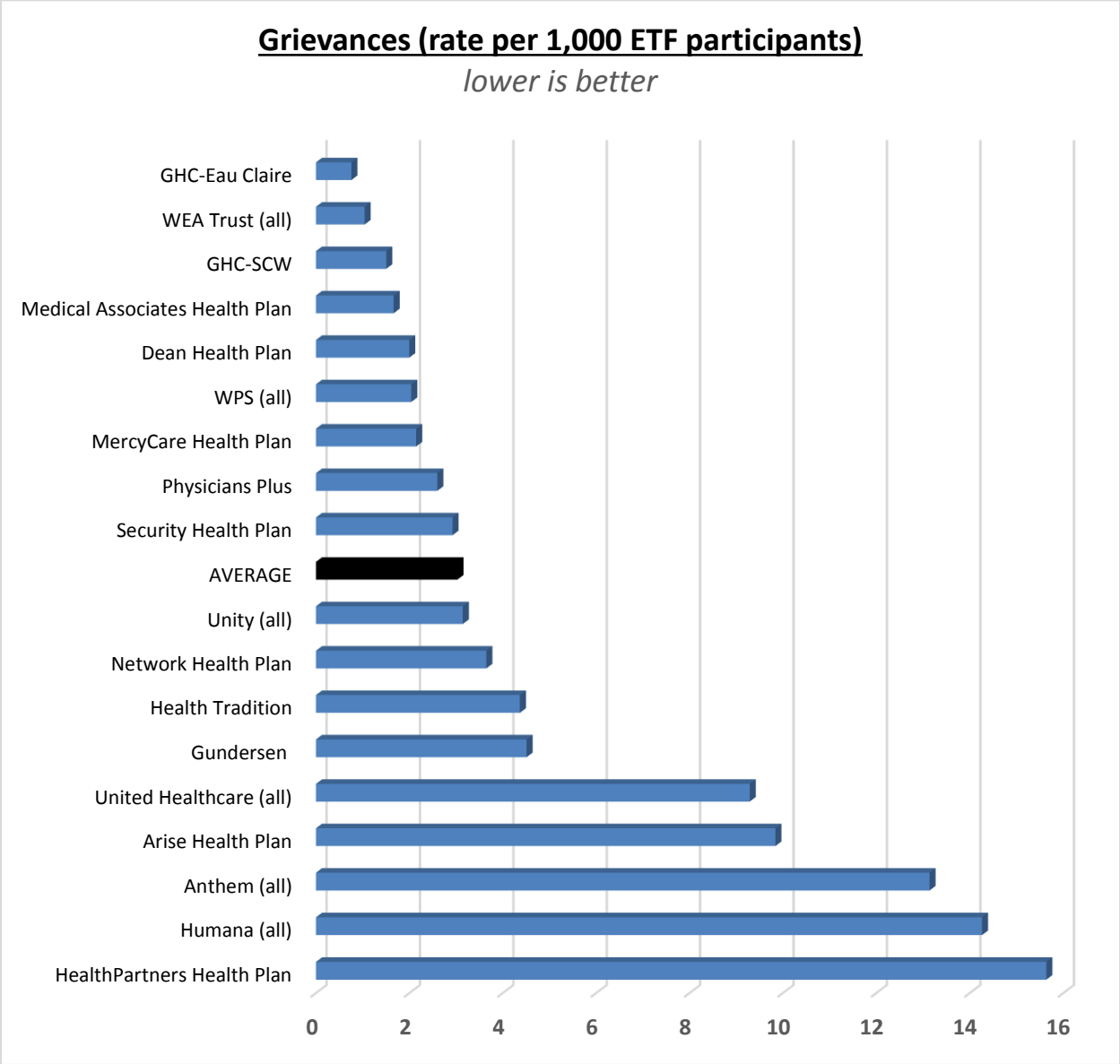
Board	Mtg Date	Item #
GIB	5.21.14	6G

- HealthPartners health plan had the highest number of grievances per 1,000 ETF participants with 16 per 1,000 (21 total). The next two highest were Humana with 14 per 1,000 (181 total) and Anthem with 13 per 1,000 (49 total). Unity had the highest raw number of grievances filed with 186 or 20% of the total for all health plans; the next two highest were Humana (181) and Dean (87). 14 plans experienced increases in grievances while 11 plans saw a decline in the number of grievances reported.



- Of the 937 grievances filed, 446 (47.5%) were resolved in favor of the member and an additional 18 grievances resulted in a compromise.
- The most common type of health plan grievance related to coverage denials based on medical necessity (250), followed by non-covered services (200) and plan service and administration (125). Over the last several years, these three grievance types have consistently been the highest categories.



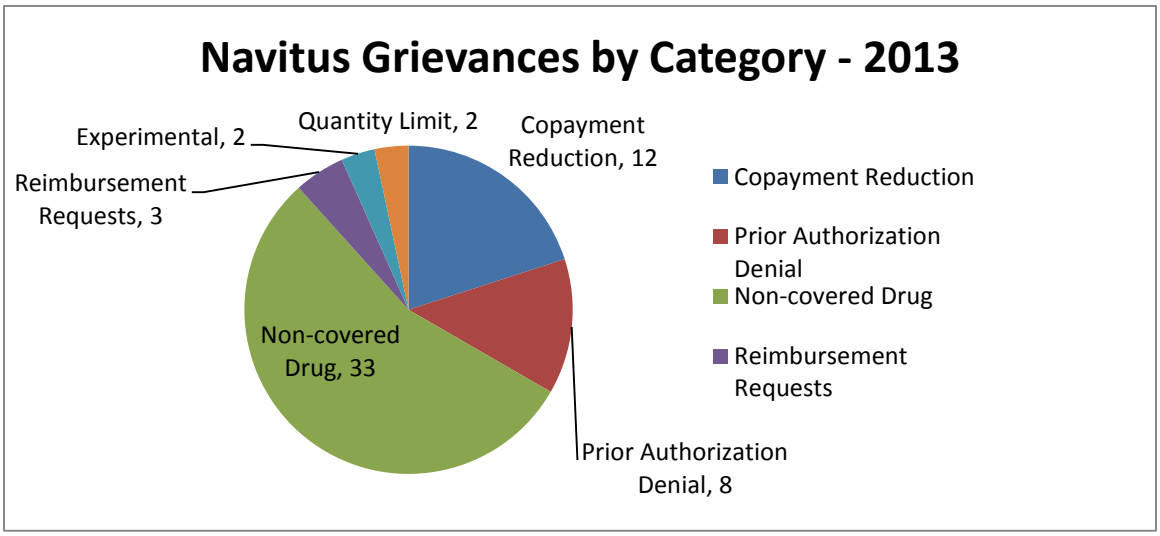


WPS includes the self-funded plans (Standard Plan, Medicare Plus and SMP) along with Metro-Choice.

2013 Pharmacy Benefit Manager Grievances

- Navitus administers the pharmacy benefit program and received 60 grievances in 2013, which was a slight increase from 53 grievances in 2012.
- 15 of the 60 pharmacy benefit grievances were resolved in favor of the member (25%).

- For Navitus, the most common types of grievances related to non-covered drugs and copayment reductions.



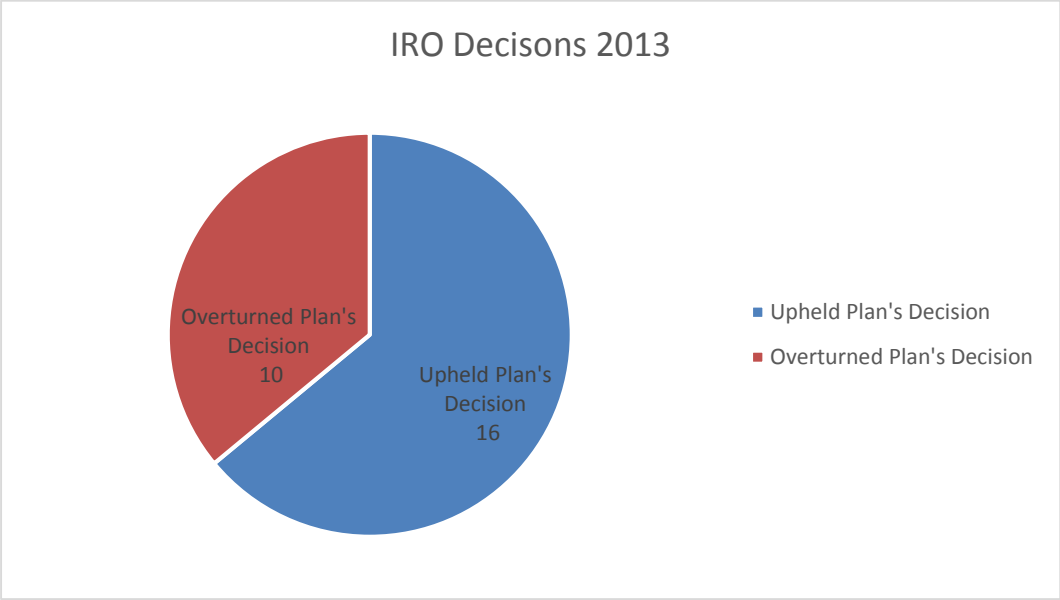
2013 Independent Reviews

This section of the 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" involving a medical judgment. Typically, these are denials of a claim or service that the plan or PBM has deemed not medically necessary or experimental. This includes denials for 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 the 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 a right to an administrative review through ETF or further appeal to the courts. 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 and process.

In 2013, there were 28 IR requests compared with 16 in 2012 and 45 in 2011. The IRO upheld the plan's grievance decision in 16 cases (61%) and overturned the plan decision in 10 cases (38%). The IRO declined to review two of the requests. This is similar to the outcomes we have seen in previous years.



In 2012, the Board approved changes in the ETF administrative review process for coverage denials eligible for IR. These changes took effect on January 1, 2014, and there could potentially be an increase in the number of IR requests by members as a result. Ombudsperson staff will monitor trends in this area and provide an update in the next report to the Board.

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