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# *Correspondence Memorandum*

**Date:** May 1, 2015

**To:** Group Insurance Board

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

**Subject:** 2014 Health Plan/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 programs administered by the Department of Employee Trust Funds (ETF). A summary of this information will also be included in the 2016 *It's Your Choice Decision Guide* and online materials.

### *2014 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. When reviewing the numbers of plan grievances as well as independent reviews that appear later in this report, it may be helpful to keep in mind that in 2014 there were just under 249,000 members and dependents insured by the program.

By contract, each health plan is required to provide a yearly grievance report to ETF. Reportable grievances are those that express member dissatisfaction with a plan decision to deny either benefits or the types of services provided by the health insurance contract. Highlights of data submitted for 2014 include:

- The number of grievances reported by health plans increased 7% from 937 in 2013 to 1,005 in 2014. This number is within the historical range in recent years (see chart).

Reviewed and approved by David Nispel, General Counsel, Legal Services
David H. Nispel
Electronically signed: 5/8/15

| Board | Mtg Date | Item # |
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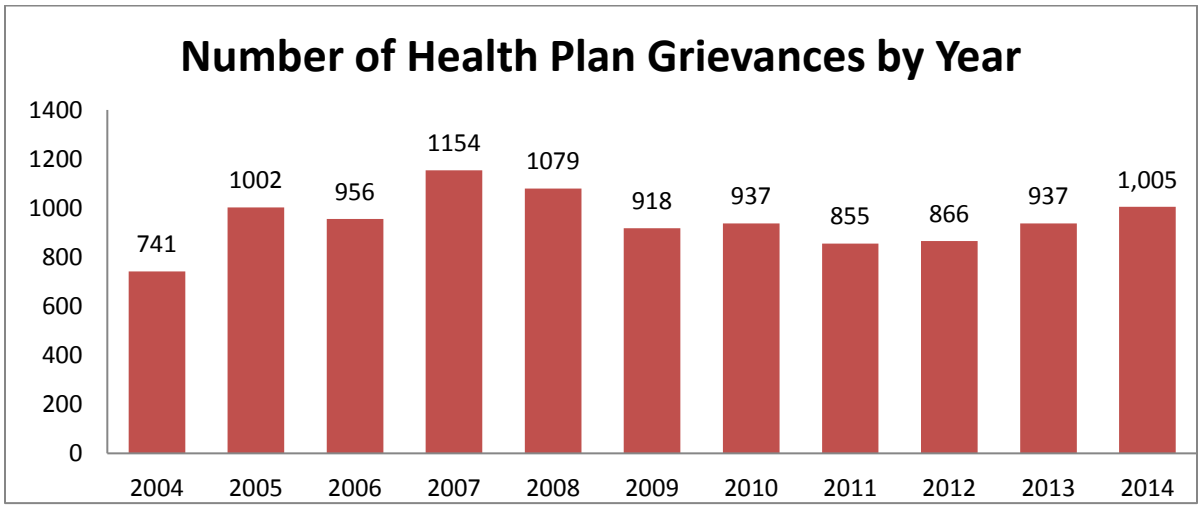
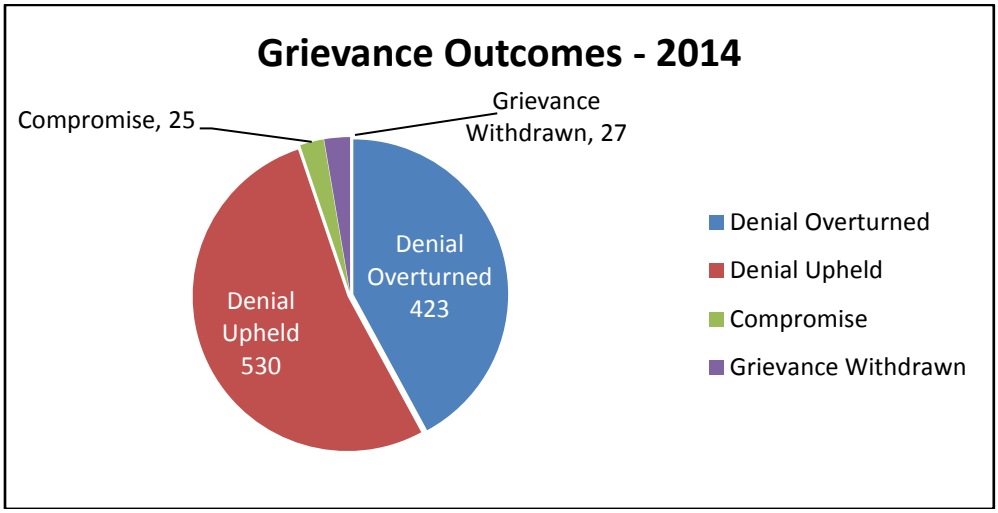


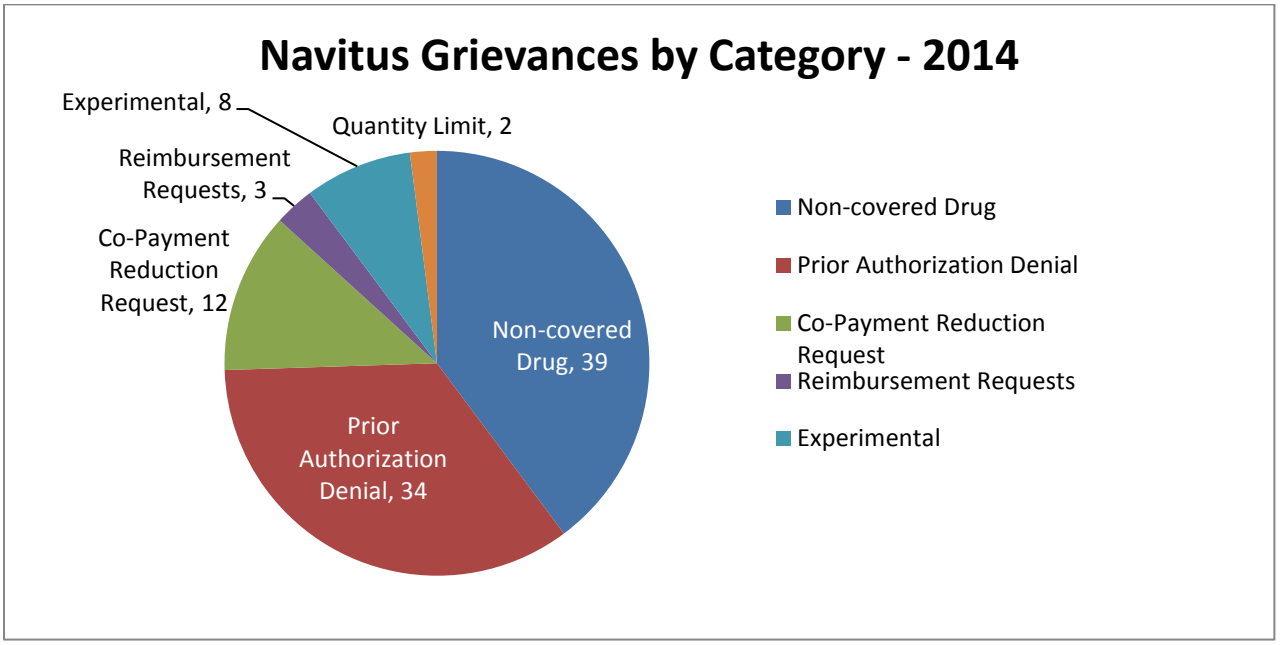

Some additional highlights from 2014 include:

- The most common type of grievance filed by State of Wisconsin members included not medically necessary (307), non-covered benefit (266) and plan service and administration (131).
- Humana had the highest number of grievances per 1,000 members, with 15. The next two highest were Anthem, with 11 per 1,000 members; and United Healthcare, with 9 per 1,000 members (see chart attached to this report for each health plan's grievances per 1,000 members).
- Unity, the plan with the largest number of participants, had the highest number of grievances un-weighted with 262.
- Of the 1,005 grievances filed, 423 (42%) were resolved in favor of the member and an additional 25 grievances resulted in a compromise for the member.
- The average number of grievances across all health plans was 3 grievances per 1,000 members.



### *2014 Pharmacy Benefit Grievances*

- In 2014, Navitus, received 98 grievances, up from 60 grievances in 2013. The bulk of the increase were grievances related to prior-authorization denials.
- The most common types of grievances were related to prior-authorization denials and non-covered drugs.
- The overturn rate for pharmacy benefit grievances was 36%.




### *2014 Independent Reviews*

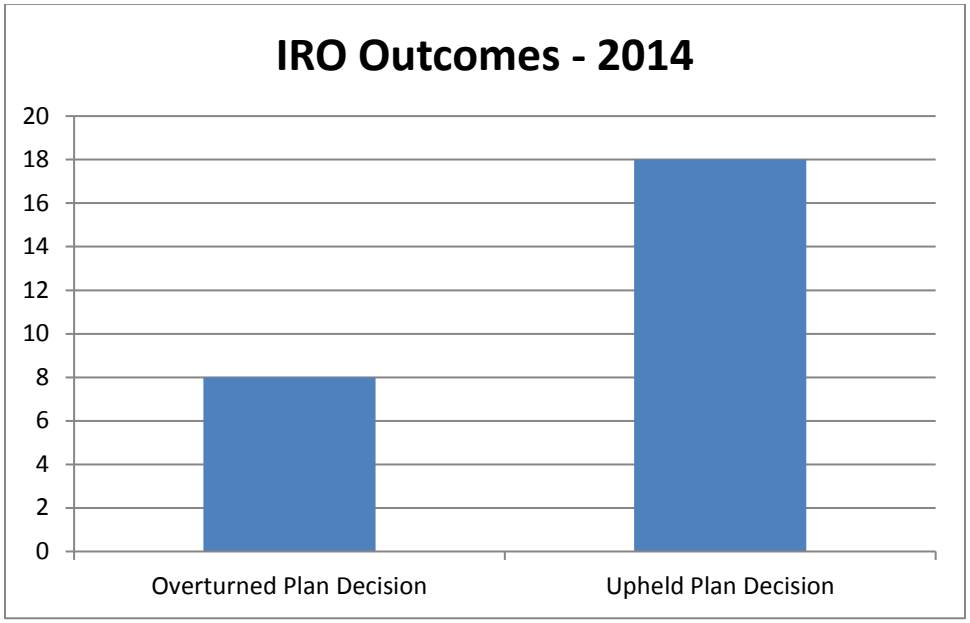
This section of the report summarizes Independent Review (IR) requests by State Group Health Insurance Program members. Members who request IRs must have completed the health plan grievance process and may have completed some steps of the ETF administrative review process. IRs are conducted by an Independent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

To be eligible for an IRO review, a member must receive an “adverse determination” involving a medical judgment. Typically, these are denials of a claim or service that the health 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

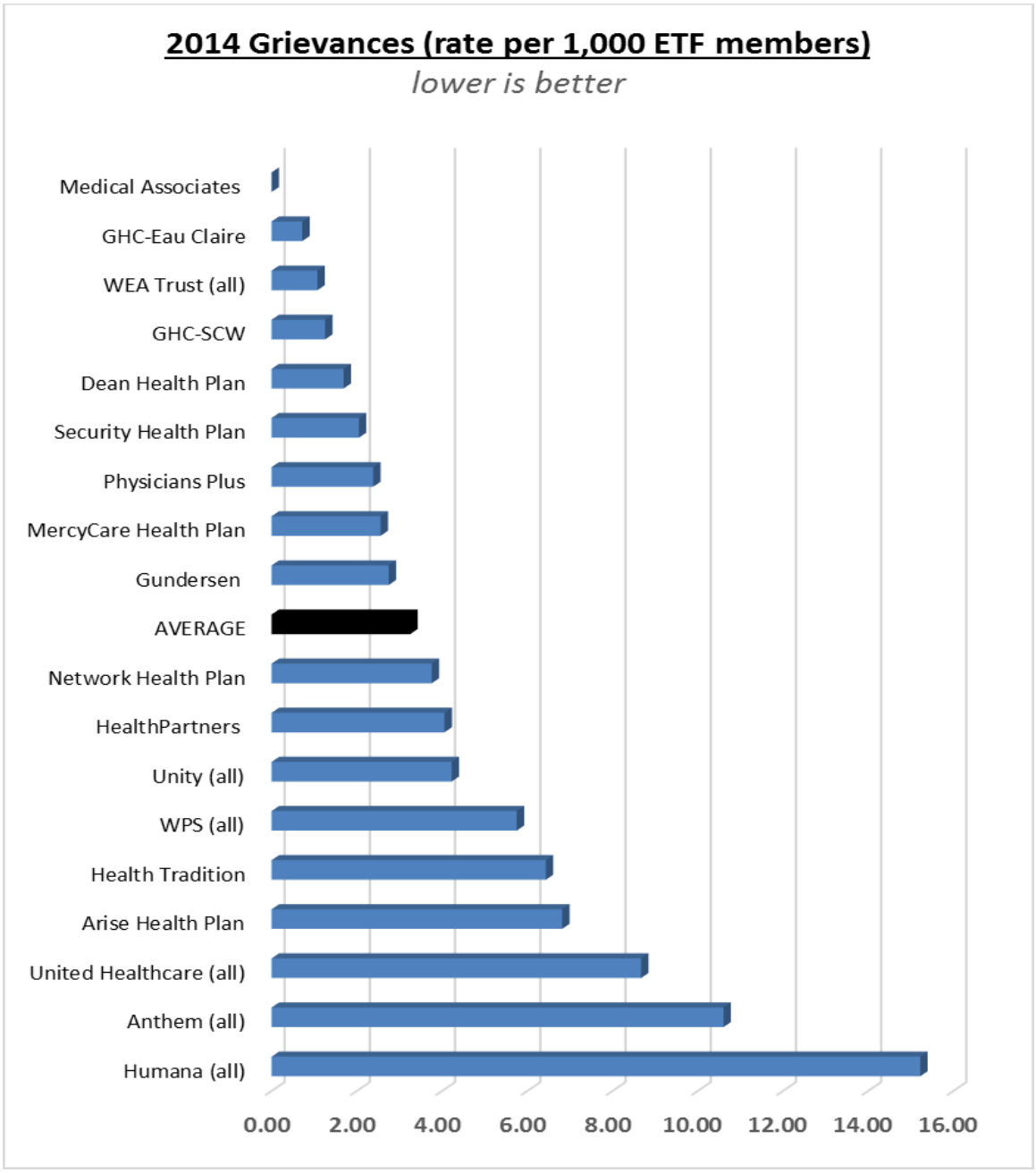
a new health insurance complaint, an ombudsperson reviews it and, if appropriate, contacts the member to educate them about the IR option and process.

In 2014, the Department was notified of 29 independent review requests from State of Wisconsin Health Insurance Program members. This remained consistent with 2013 when there was 28 requests. The independent review organizations overturned the plan decision in eight of the cases and upheld the plan decision in 18 of the cases. Three requests were determined to not be eligible for review and were declined for review by the IROs.




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

Attachment A: 2014 Grievances Chart




Item 7B GIB 5.19.25

**Attachment A**