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Correspondence Memorandum

Date: April 17, 2018

To: Group Insurance Board

From: Liz Doss-Anderson, Ombudsperson
James Kates, Ombudsperson
Mary Richardson, Ombudsperson
Dan Hayes, Attorney/Supervisor

Subject: 2017 Health Plan and Pharmacy Benefit Manager Grievance and External 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 2018 It's Your Choice online materials. Please note that throughout the report there are areas with incomplete data because the following plans no longer participate in the State Group Health Insurance Program and were not contractually obligated to submit information: Anthem, Arise, Health Tradition, Humana, UnitedHealthcare, in addition to WPS as administrator of the self-funded plans.

2017 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 that remain in the program for 2018. This report also includes grievance data for Navitus Health Solutions (Navitus), the pharmacy benefits manager, and Delta Dental, administrator for Uniform Dental Benefits. When reviewing the numbers of plan grievances and independent reviews that appear later in the report, it is beneficial to keep in mind that in 2017 there were approximately 242,000 members and dependents insured by the State of Wisconsin Group Health Benefits Program.

- The total number of reported grievances in 2017 was 655. Again, this number does not include grievances of the plans that left the program after 2017. These plans accounted for 302 of the 928 grievances reported in 2015 and 320 of the 1003 grievances reported in 2016. If the average of these two years (311) were

Reviewed and approved by David Nispel, General Counsel, Legal Services
David H. Nispel Electronically Signed 4/30/18

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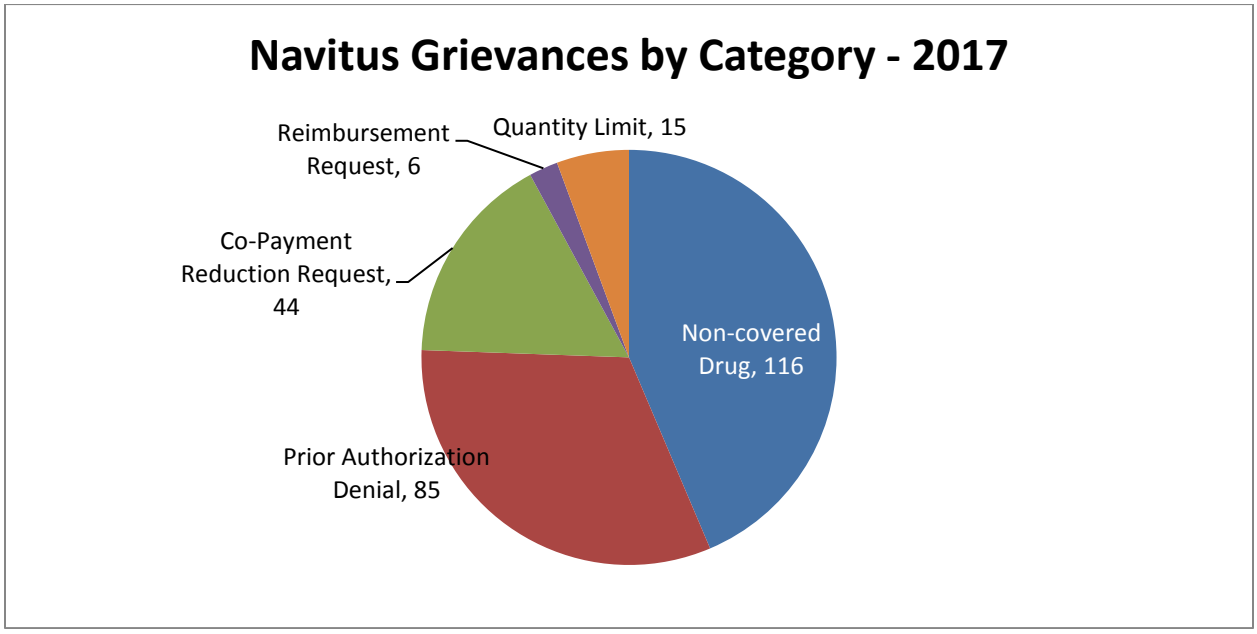
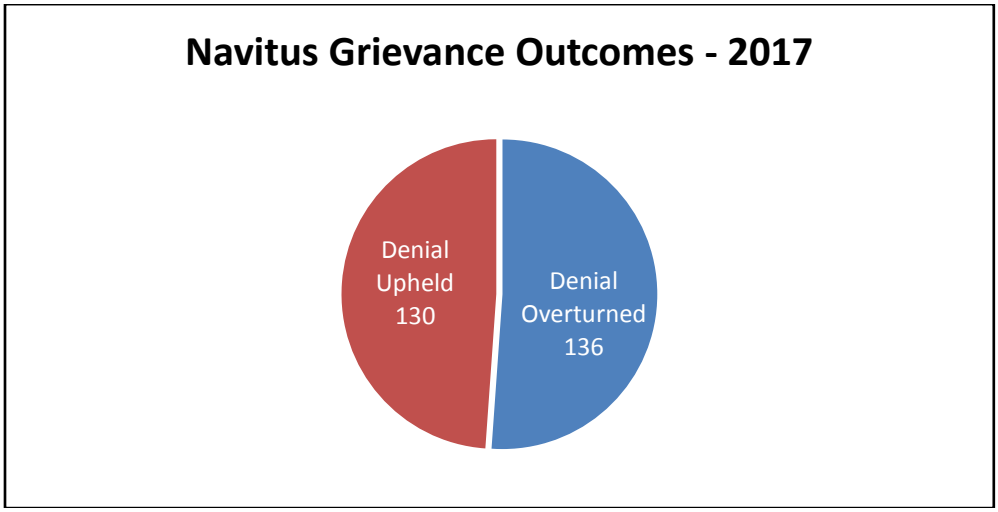
added to the grievances reported in 2017, the total would have been 966 which is consistent with grievance numbers for the past several years.

- As in prior years, the most common types of grievances related to denials of coverage for services considered not medically necessary (212), for non-covered benefits (97), for out of network (87), and prior authorization denials (73).
- Of the 655 grievances filed, 272 were either resolved in favor of the member or resulted in a compromise.
- Security Health Plan had the highest number of grievances per 1,000 members with 6.73 per 1,000. The next two highest were Network Health with 6.72 and HealthPartners with 4.64.
- Delta Dental, plan administrator for Uniform Dental Benefits, had 13 grievances and served 198,046 members. The most common type of dental grievance was for non-covered benefits.

2017 Pharmacy Benefit Grievances

- In 2017, Navitus received 266 grievances, consistent with 2016 when members filed 278 grievances.
- The most common type of pharmacy benefit grievance was for Non-Covered Drug (116). This was followed by Co-Payment Reduction Denial (91), followed by prior authorization denial (85).
- The overturn rate for pharmacy benefit grievances was 51%, up from 34% in 2016.
- Factors affecting the grievances include changes in the formulary, prior authorizations for experimental or not medically necessary drugs and members interested in non-formulary/non-covered drugs.





2017 External Reviews

This section of the report provides a summary of External Review requests by State of Wisconsin Group Health Insurance program members. Members who request External Reviews must have completed the health plan grievance process and may have completed some steps of the ETF administrative review process. External Reviews are conducted by an independent review organization (IRO) that is independent of both ETF and the individual health plans.

To be eligible for an External Review, a member must receive an "adverse determination" involving a medical judgment. Such medically-based determinations are only eligible for External Review and may not be appealed to the Board pursuant to contract. Typically, these are denials of a claim or service 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 member's medical condition because the expertise is not available in the insurer's provider network.

The External Review 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. Thus, 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 External Review option and process.

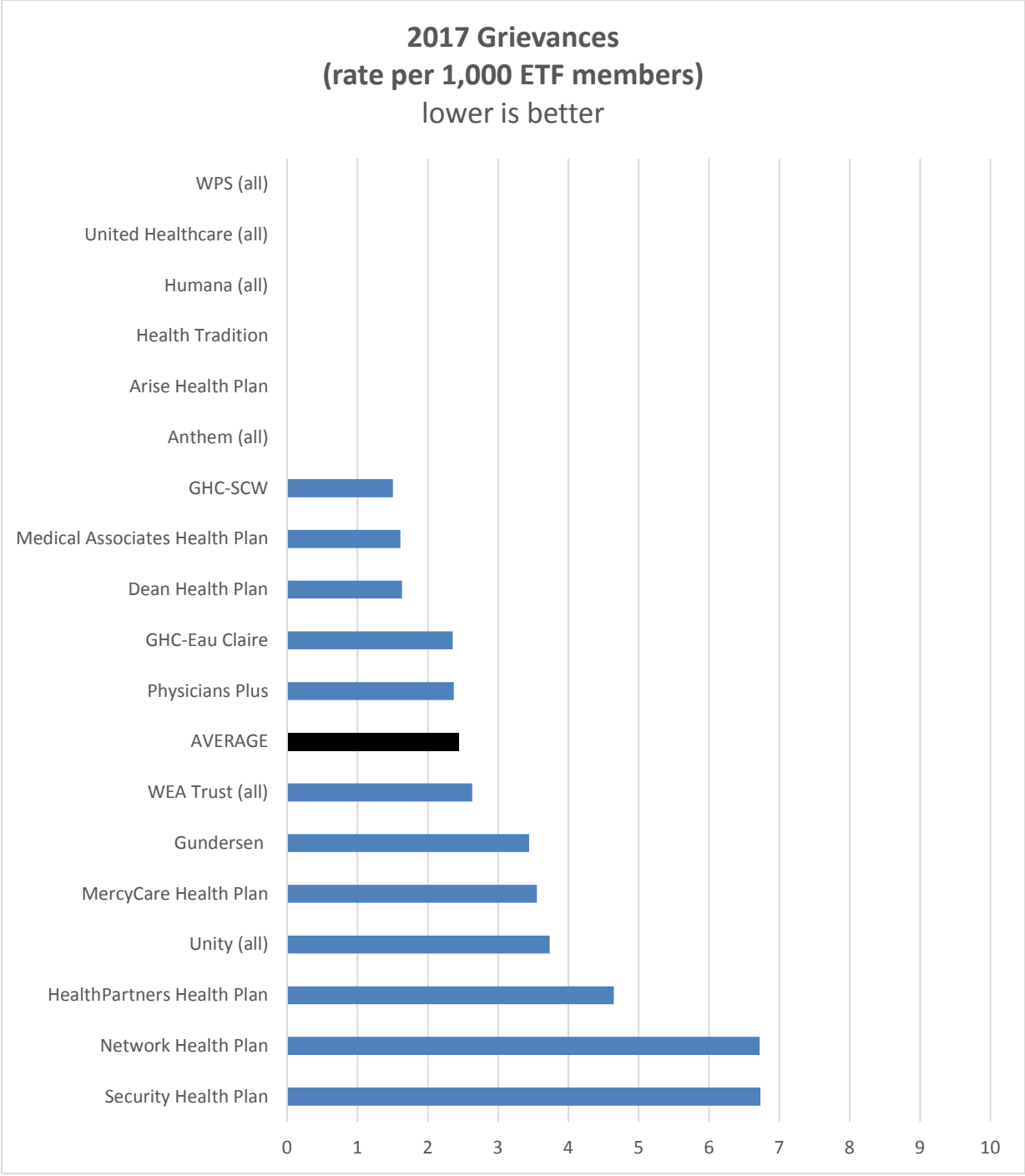
In 2017 the Department was informed of 34 external review requests from members. Although this number is far below the 2016 total of 72, seven fewer health plans submitted the requested information (if the total number of External Review requests from the those plans in 2016 are added, the total would be 64). The independent review

organization overturned the plan decision in 11 cases and upheld the plan decision in 20 cases. There were 3 cases in which the IRO declined to review the member's request as not eligible for review.

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

Attachment A

2017 Complaints Chart



Grievances by Health Plan
2015-2017

HEALTH PLAN	2015 Grievances	2016 Grievances	2017 Grievances	Net Change (2016-2017)	Number of Members (2017)
Anthem Blue-NE	26	11	**	**	4,261
Anthem Blue-SE	76	47	N/A	N/A	0
Arise Health Plan	8	8	**	**	1,728
Dean Health Plan	82	98	112	14	39,445
Dean Prevea360	0	1	3	2	339
GHC of Eau Claire	1	1	3	2	1,274
GHC of South Central Wisconsin	26	27	21	(6)	13,969
Gundersen Health Plan	32	19	22	3	6,392
HealthPartners Health Plan	15	9	17	8	3,660
Health Tradition	22	19	**	**	4,618
Humana Eastern	140	195	**	**	13,680
Humana Western	18	20	**	**	1,136
Medical Associates Health Plan	0	1	3	2	1,864
MercyCare Health Plan	9	8	5	(3)	1,408
Network Health Plan	43	66	59	(7)	8,783
Physicians Plus	33	46	31	(15)	13,079
Security Health Plan	35	41	60	21	8,916
UnitedHealthcare	50	33	**	**	14,294
Unity-Community	41	57	79	22	14,667
Unity-UW Health	182	200	177	(23)	53,791
WEA Trust-East	28	40	38	(2)	15,227
WEA Trust-NW Mayo Clinic System	6	10	20	10	5,557
WEA Trust-NW Chippewa Valley	15	11	5	(6)	3,135
WEA Trust-South Central WI	2	1	N/A	N/A	0
WPS Self-Funded Plans	38	34	**	**	10,812
TOTAL	**928**	**1003**	**655**	**4[A]**	**242,035**

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

***Plan not required to report 2017 grievance numbers.*

[A] Net Change for Plans Reporting, Only.