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Correspondence Memorandum

Date: April 20, 2021

To: Group Insurance Board

From: Dan Hayes, Attorney/Supervisor
Liz Doss-Anderson, Ombudsperson
Mary Richardson, Ombudsperson
Office of Legal Services

Subject: 2020 Health Plan and Pharmacy Benefit Manager (PBM) 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, pharmacy benefit and Uniform Dental Benefit programs administered by the Department of Employee Trust Funds (ETF). A summary of this information will also be included in the 2021 *It's Your Choice* online materials.

2020 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, and Delta Dental, the third-party 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 2020 there were approximately 239,000 members and dependents insured by the State of Wisconsin Group Health Insurance Program.

- The total number of health plan grievances reported in 2020 was 618, down from 804 in 2019, a decrease of 186 grievances. This may be due to members not seeking specialty care and elective services during the pandemic.
- As in prior years, the most common types of grievances are related to:
 - Denials of coverage for services considered not medically necessary (219)
 - Non-covered benefits (87)
 - Prior authorizations (86)

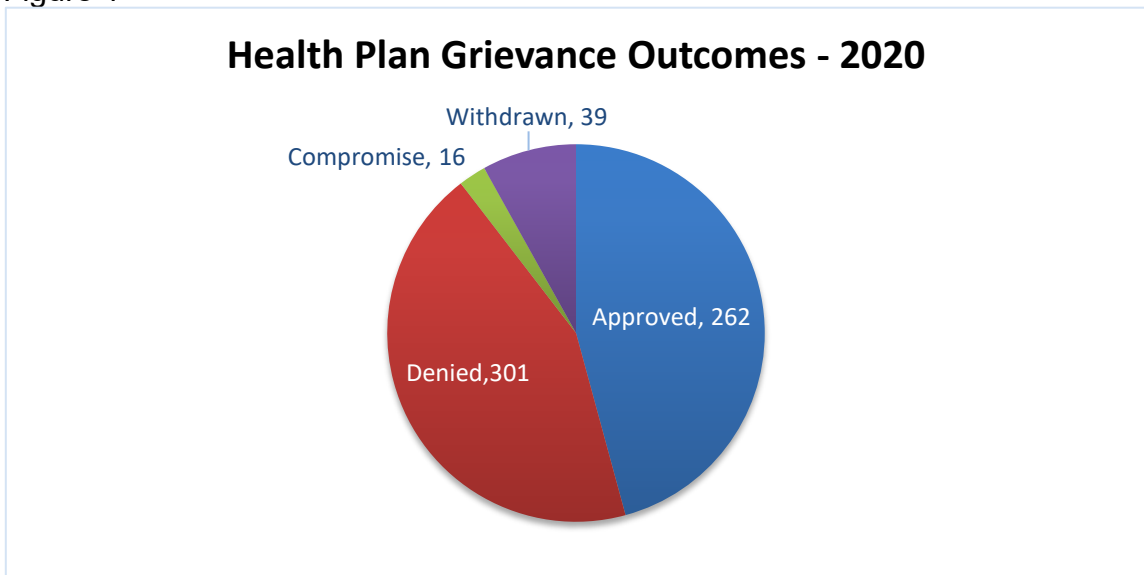
Reviewed and approved by David Nispel, General Counsel,
Office of Legal Services

Electronically Signed 4/30/21

Board	Mtg Date	Item #
GIB	5.12.21	14K

- Of the 618 grievances filed, 278 were either resolved in favor of the member or resulted in a compromise, a 45% overturn rate. This is a slightly higher rate than in the past several years when the overturn rate has been closer to 42%.
- Of note, there were several plans that had multiple grievances involving denial of Continuous Glucose Monitors (CGMs). These grievances, in addition to the contacts to Ombudsperson Services in 2019 and 2020, resulted in the Office of Strategic Health Policy reviewing coverage for CGMs and making a recommendation to the Group Insurance Board to move coverage of CGMs from the medical benefit to the pharmacy benefit in 2022. This will help improve access to CGMs and required supplies.
- Delta Dental had six grievances and served 204,206 members with Uniform Dental Benefits. The most common type of dental grievance related to a non-covered benefit.

Figure 1



2020 Pharmacy Benefit Grievances

- In 2020, Navitus received 361 grievances, an increase of 38 from the 323 filed in 2019.
- Consistent with prior years, the most common types of pharmacy benefit grievance were for Non-Covered Drug (166), Prior-Authorization Denial (166) and Quantity Limits (20).
- Navitus overturned 217 grievances. The overturn rate for pharmacy benefit grievances continues to increase by a few percentage points over the last few years: 60% in 2020, 58% in 2019, 57% in 2018 and 51% in 2017.
- Factors affecting pharmacy benefit grievances included changes in the formulary, members interested in non-covered/non-formulary drugs, requests for an exception to coverage, and requests for experimental or non-medically

necessary drugs. To assist members' understanding of their pharmacy benefits, ETF has made the Navitus formularies available on the ETF website.

Figure 2

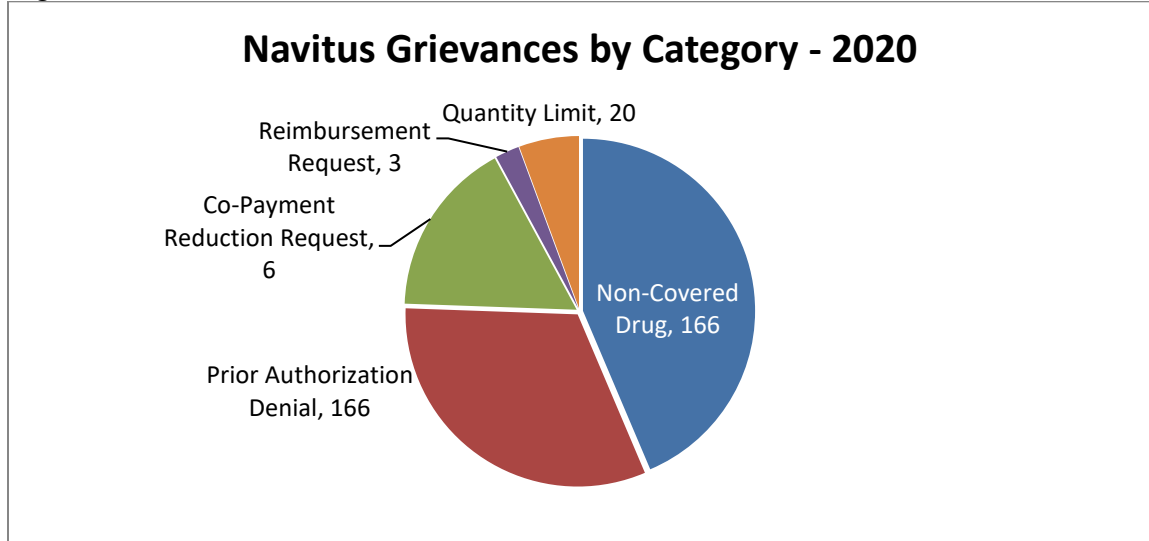
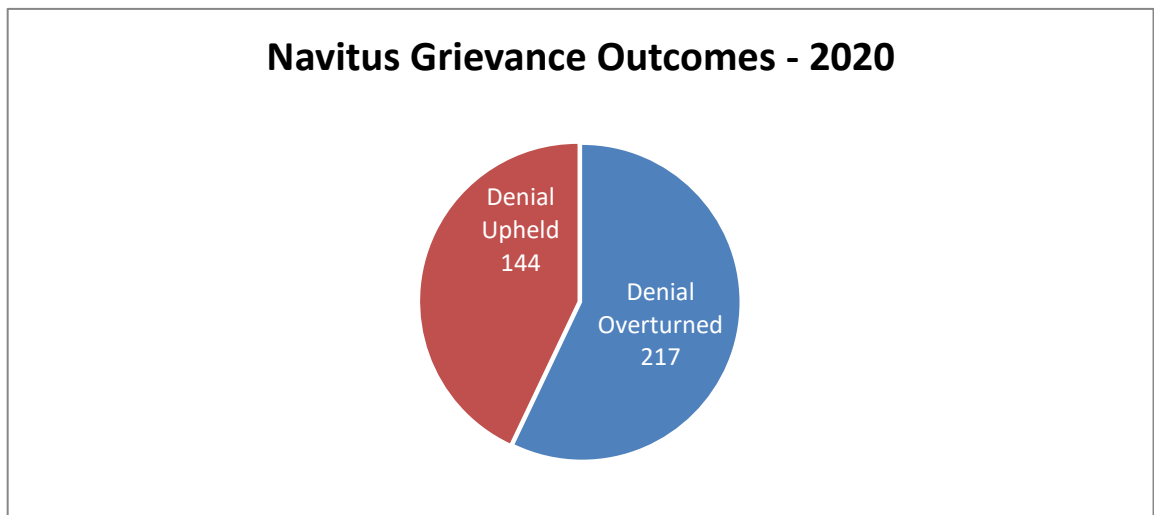


Figure 3



2020 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 plan grievance process. External reviews are conducted by an independent review organization (IRO) that is independent of both ETF and the individual plans.

To be eligible for 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, PBM or dental vendor 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 through the insurer's provider network.

The external review process allows members to have an outside medical expert review their grievance and determine if benefits are payable. The IRO's decision is binding on both the plan and the member, so 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 2020, ETF was informed of 71 external review requests from members, which is a decrease from 94 reported in 2019. This number has remained consistent over the last the last few years. The independent review organization overturned the plan decision in 19 cases and upheld the plan decision in 48 cases. There were four cases in which the IRO determined the member's request was not eligible for review.

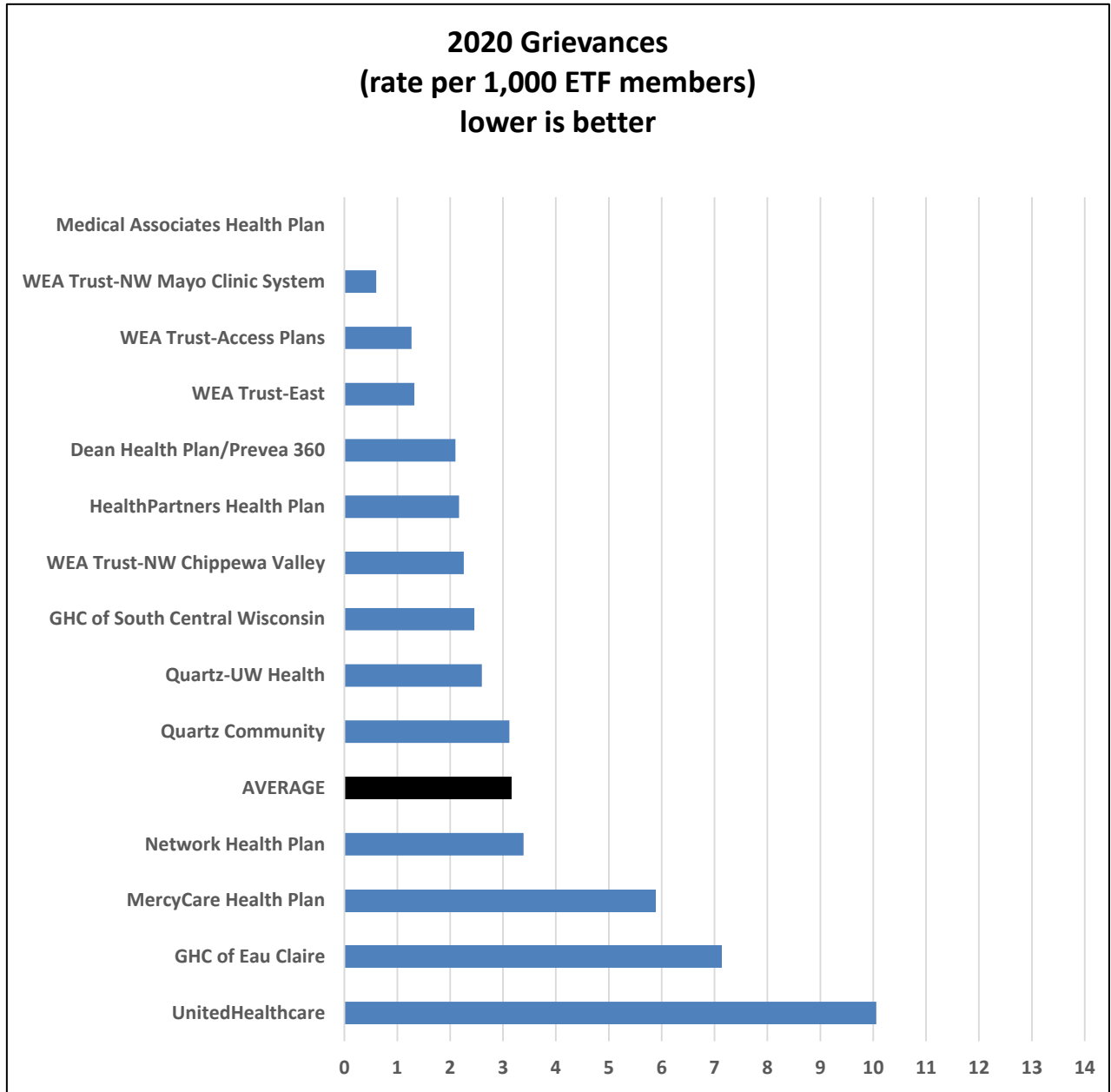
New this year, Health Plans and the PBM and the Uniform Dental plan are required to send ETF a redacted version of the IRO outcome (to preserve member privacy) for any Group Health Insurance Program (GHIP) members who complete the IRO process. These letters will be shared with the Office of Strategic Health Policy to help improve the GHIP by learning about new procedures and medications that are being approved or denied by IROs and to gain a better understanding of how our benefits may provide or limit access. In addition, Ombudsperson Services continues to monitor plan grievance letters to ensure that plans are utilizing the correct ETF contract citations, administrative review rights and external review rights, when appropriate. When deficiencies are found with a plan, their Account Executive is notified of the need for corrective action.

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

Attachment A: 2020 Complaints Chart

Attachment B: Grievances by Health Plan 2018-2020 Chart

Attachment A



Attachment B

**Grievances by Health Plan
 2018-2020**

HEALTH PLAN	2018 Grievances	2019 Grievances	2020 Grievances	Net Change (2019-2020)	Number of Members (2020)
Dean Health Plan/Prevea 360	110	129	97	-32	46,079
GHC of Eau Claire	13	3	15	+12	2,101
GHC of South Central Wisconsin	13	34	32	-2	12,961
HealthPartners Health Plan	25	15	16	+1	7,363
Medical Associates Health Plan	3	0	0	-	3,019
MercyCare Health Plan	4	0	9	+9	1,528
Network Health Plan	130	117	69	-48	20,325
Physicians Plus	3	**	**	*	*
Quartz-Community	90	62	43	-19	13,763
Quartz-UW Health	233	235	175	-60	67,179
Security Health Plan	49	61	**	*	*
UnitedHealthcare	**	91	91	-	9,041
WEA Trust-East	50	41	46	+5	34,595
WEA Trust-NW Mayo Clinic System	14	9	5	-4	8,248
WEA Trust-NW Chippewa Valley	5	0	8	+8	3,537
WEA Trust-Access Plans	4	7	12	+5	9,393
TOTAL	655	804	618	-186	239,132

*** Plan not required to report grievance numbers where indicated.*

**Net change listed only for plans reporting in 2020*