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Correspondence Memorandum

Date: April 10, 2022

To: Group Insurance Board

From: Liz Doss-Anderson, Ombudsperson
Mary Richardson, Ombudsperson
Office of the Secretary

Subject: 2021 Health Plan and Pharmacy Benefit Manager (PBM) 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, pharmacy benefit, employee reimbursement accounts (ERA) 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 2022 *It's Your Choice* online materials.

2021 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 benefit manager; Delta Dental, third-party administrator for Uniform Dental Benefits; and Optum, third-party administrator for ERAs. 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 2021 there were 227,972 members and dependents insured by the State of Wisconsin Group Health Insurance Program (GHIP), which is comparable to 2020 membership.

- The total number of grievances reported in 2021 was 679, up from 618 in 2020, an increase of 61 grievances.
- As in prior years, the most common types of grievances are related to the following:
  - Denials of coverage for services considered not medically necessary (271)
  - Non-covered benefits (118)
  - Prior authorizations (74)
- Of the 679 grievances filed, 310 were either resolved in favor of the member or resulted in a compromise, a 46% overturn rate. This is consistent with recent

Reviewed and approved by Pamela Henning, Assistant Deputy Secretary Electronically Signed 05/05/2022
Pamela L Henning

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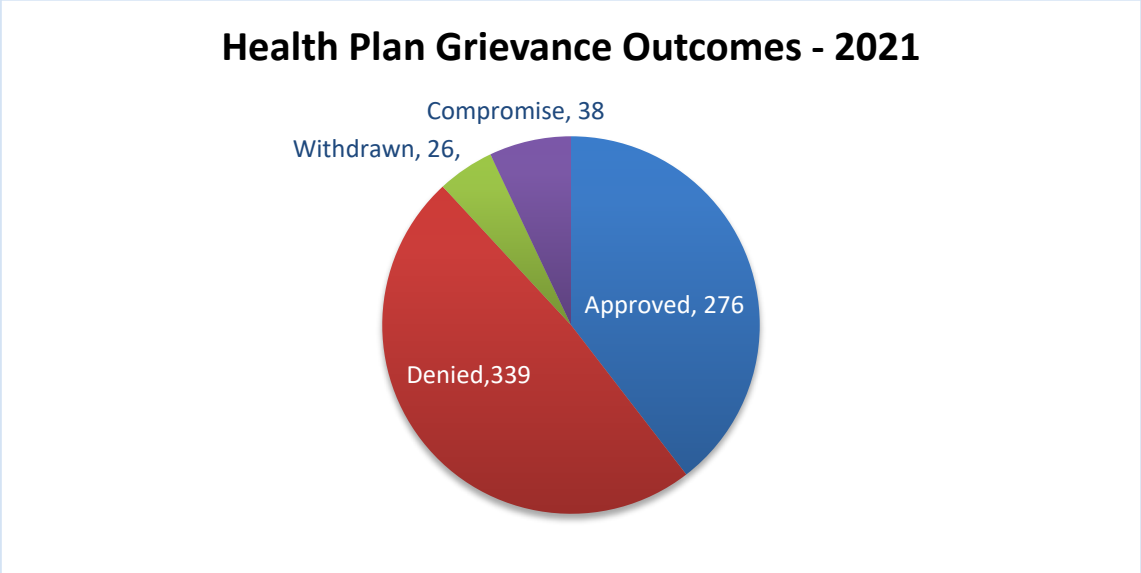
years' overturn rates between 42% and 45% and demonstrates the value of working with the plans to resolve member issues.

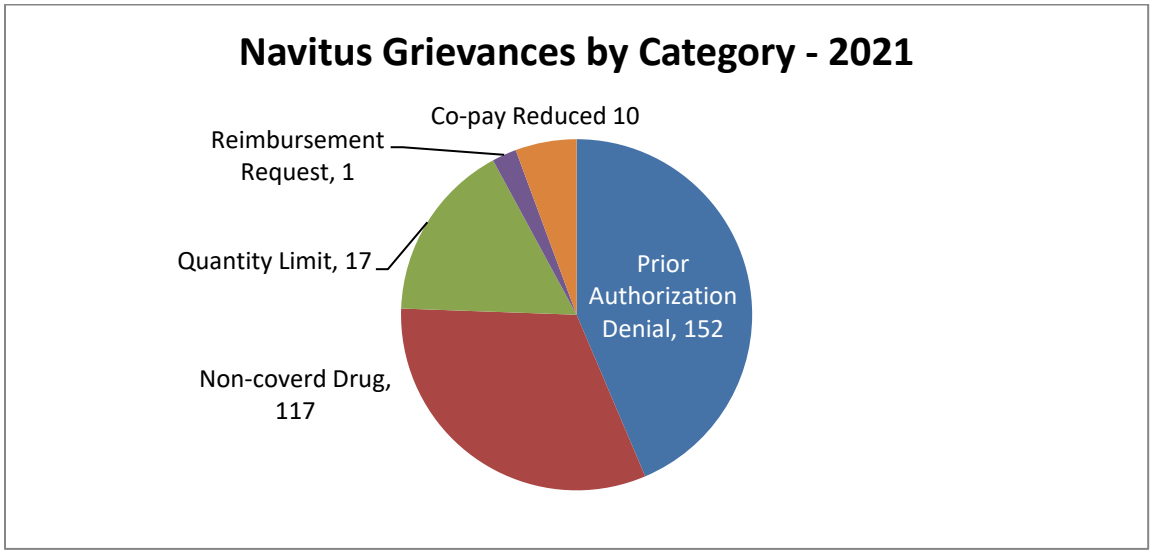
- Delta Dental had 10 grievances and served 205,692 members with Uniform Dental Benefits. The most common types of dental grievances related to non-covered benefits and access to providers.
- Optum, the administrator for our ERA program (which includes Flexible Spending Accounts, Dependent Day Care Accounts, Health Savings Accounts and Parking/Transit), had 226 grievances for 29,882 members. Enrollment and eligibility grievances was the most common grievance type, with 192 and an overturn rate of 85%. Most of these grievances (60%) were related to members rescinding their applications for enrollment or incomplete documentation. Unsubstantiated Claim Appeal was the second-highest type, with 33 grievances and an overturn rate of 15%.



2021 Pharmacy Benefit Grievances

- In 2021 Navitus received 301 grievances, a decrease of 60 from the 361 filed in 2020.
- Consistent with prior years, the most common types of pharmacy benefit grievance were for Prior-Authorization Denial (152), Non-Covered Drug (117) and Quantity Limits (17).
- Navitus overturned 149 grievances. The overturn rate for pharmacy benefit grievances dropped in 2021 to 50% from 60% in 2020 and 58% in 2019. Overturn rates at 50% reinforces the importance of completing the PBM grievance process.
- 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 continues to have the Navitus formularies available via the ETF website.



2021 External Reviews

This section of this report provides a summary of external review requests by GHIP members. An external review is a request from a member who has completed the plan grievance process but wishes to continue on to receive an opinion from an independent review organization (IRO) that is independent of both ETF and the individual plans. 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.

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.

In 2021 ETF was informed of 25 external review requests from members, which is a decrease from 71 reported in 2020. The independent review organization overturned the plan decision in 10 cases and upheld the plan decision in 12 cases. There were three cases in which the IRO determined the member's request as not eligible for review. Ombudsperson Services is of the opinion that with 271 (see page 1)grievances eligible for external review, the decrease in requests suggest the need for more education for members on the benefit of the Independent Review process as

oftentimes, members are unaware of the IR process. We continue to monitor plan grievance decision letters to ensure members are receiving appropriate independent review rights. Health Plans, the PBM and Delta Dental's Uniform Dental Benefits plan are required to send ETF a redacted version of the external review outcome (to preserve member privacy) for any GHIP members who complete the external review process. These external review outcomes will be shared with the Office of Strategic Health Policy (OSHP) to help improve the GHIP by learning about 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 and 2021 Grievances Per 1,000 Members Chart

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