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Correspondence Memorandum

Date: April 21, 2023

To: Group Insurance Board

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

Subject: 2022 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, Uniform Dental Benefit programs and employee reimbursement accounts (ERA) administered by the Department of Employee Trust Funds (ETF). A summary of this information will also be included in the 2024 *It's Your Choice* online materials.

2022 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 (GHIP), excluding the Well Wisconsin Program. GHIP is defined as including wellness, health, pharmacy, and uniform dental programs. This report also includes grievance data for Optum, the 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 2022 there were 238,838 members and dependents insured by the GHIP, which is comparable to 2021 membership.

The total number of grievances reported in 2022 was 1,085, up from 679 in 2021, an increase of 406 grievances. As in prior years, the most common types of grievances are related to denials of coverage for services considered not medically necessary (400), non-covered benefits (173), prior authorizations (161), and plan service and administration (123).

Pamela L Henning

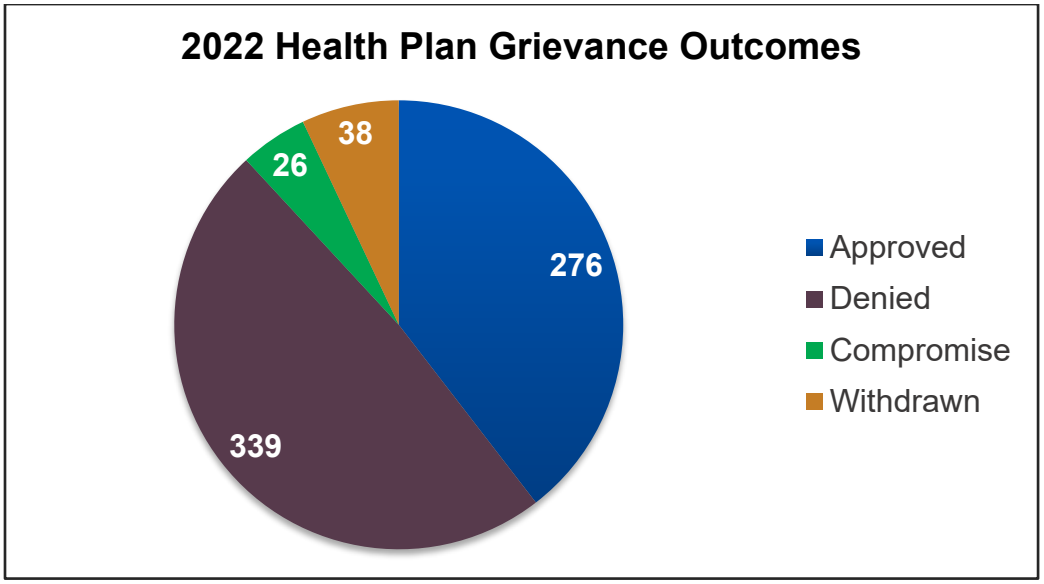
Reviewed and approved by Pam Henning, Assistant Deputy Secretary
Electronically Signed 04/26/2023

Board	Mtg Date	Item #
GIB	05.17.23	8J

Of the 1,085 grievances filed, 480 were either resolved in favor of the member or resulted in a compromise, a 44% overturn rate. This is consistent with recent years' overturn rates between 42% and 46% and demonstrates the value of working with the plans to resolve member issues.

Delta Dental had seven grievances and served 203,896 members with Uniform Dental Benefits. The most common types of dental grievances are related to non-covered benefits.

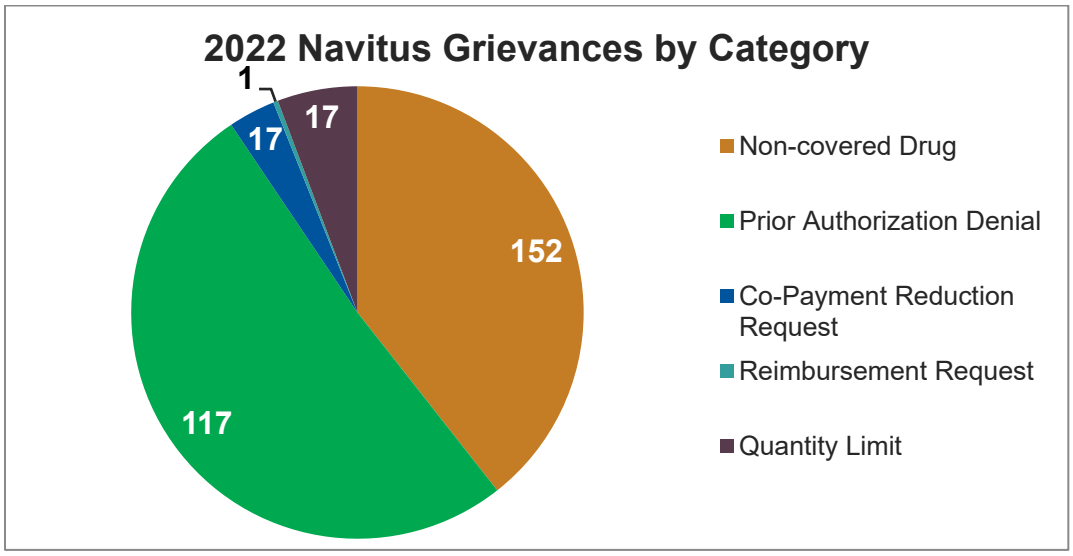
Optum, the administrator for our ERA program (which includes Flexible Spending Accounts, Dependent Day Care Accounts, Health Savings Accounts, and Parking/Transit), had 389 grievances for 36,872 members. Enrollment and eligibility grievances were the most common grievance type, with 360 and an overturn rate of 87%. Most of these grievances were related to members rescinding their applications for enrollment or incomplete documentation needed to complete enrollment. Unsubstantiated Claim appeal was the second-highest type, with 29 grievances. These members have the ETF Unsubstantiated Business Debt Appeal process available to them after completing the grievance process at Optum.



2022 Pharmacy Benefit Grievances
In 2022, Navitus received 514 grievances, an increase of 213 from the 301 filed in 2021. Consistent with prior years, the most common types of pharmacy benefit grievances were for Prior-Authorization Denial (242), Non-Covered Drug (181), Quantity Limits (40), and not medically necessary (22).

Navitus overturned 251 grievances in 2022. The overturn rate for pharmacy benefit grievances dropped to 49% in 2022 from a record high of 60% in 2020. High overturn rates reinforce the importance of members utilizing 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. In addition, the number of prescriptions has increased by 4.8%. To assist members' understanding of their pharmacy benefits, ETF continues to have the Navitus formularies available via the ETF website.



2022 External Reviews

An external review is a request from a member who has completed the plan grievance process but wishes to continue 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 the 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 the treatment of the member's medical condition because the expertise is not available through the insurer's provider network.

The current program agreement requires that ETF be notified of member requests for IRO. In 2022, ETF was notified of 50 external review requests from members in traditional health plans, which is an increase of 25 reported in 2022. The IROs overturned the plan decision in 15 cases and upheld the plan decision in 34 cases. There was one case in which the IRO determined the member's request was not eligible

for review. In addition, the UnitedHealthcare-MA program, deemed part of ETF's GHIP, reported 78 requests. Medicare Advantage plans are required to send all eligible denials for IRO review.

We continue to monitor plan grievance decision letters to ensure members are receiving appropriate independent review rights. Health Plans, Navitus 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: 2021 and 2022 Grievances Per 1,000 Members Chart