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Correspondence Memorandum

Date: April 26, 2024

To: Group Insurance Board

From: Liz Doss-Anderson, Ombudsperson
Peggy McCullick, Ombudsperson
Office of the Secretary

Subject: 2023 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 open enrollment online materials.

2023 Plan Grievances
Plan grievances are filed directly with a plan/vendor and reviewed by the internal grievance committee. If the member receives an unfavorable outcome, the member is advised of their additional avenues of appeal. Grievances denied due to medical necessity or experimental in nature are given Independent Review Rights for an external review by a medical review organization known as an Independent Review Organization (IRO). The IRO decision is binding. Grievances denied related to contract provisions are eligible for an ETF administrative review.

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). This report also includes grievance data for the ERA, pharmacy benefit management (PBM), and dental benefit programs. Total membership in 2023 was comparable to total membership in 2022 for these programs.

The total number of grievances reported in 2023 was 1,390, which was an increase of 305 grievances from 2022. As in prior years, the most common types of grievances in 2023 are related to denials of coverage for services considered not medically necessary (502), plan service and administration (210), prior authorizations (190), and (157) non-

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Reviewed and approved by Pam Henning, Assistant Deputy Secretary
Electronically Signed 05/08/2024

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covered benefits. Attachment A details the number of grievances per 1,000 members, by plan. Please note, UnitedHealthcare (UHC) Medicare Advantage and Medicare Plus (administered by UHC) are not included in Attachment A as these two plans are inherently different than the listed HMO plans. This is due to nationwide networks and applicable Medicare rules governing both plans. In 2022 there were 34 grievances per 1,000 members and in 2023 there were 25 grievances per 1,000 members.

Of the 1,390 grievances filed, 800 were either resolved in favor of the member or resulted in a compromise, a 58% overturn rate. This is an increase in overturn rates compared to 2022 where the overturn rate was 46%. High overturn rate demonstrates the value of working with the plans to resolve member issues. OS staff work with plans on an individual basis, as needed, to educate plan grievance staff on contract and Uniform Benefits interpretations provided to our members. OS staff have discussed issues with plans at the quarterly Council on Health Plan Improvements meetings.

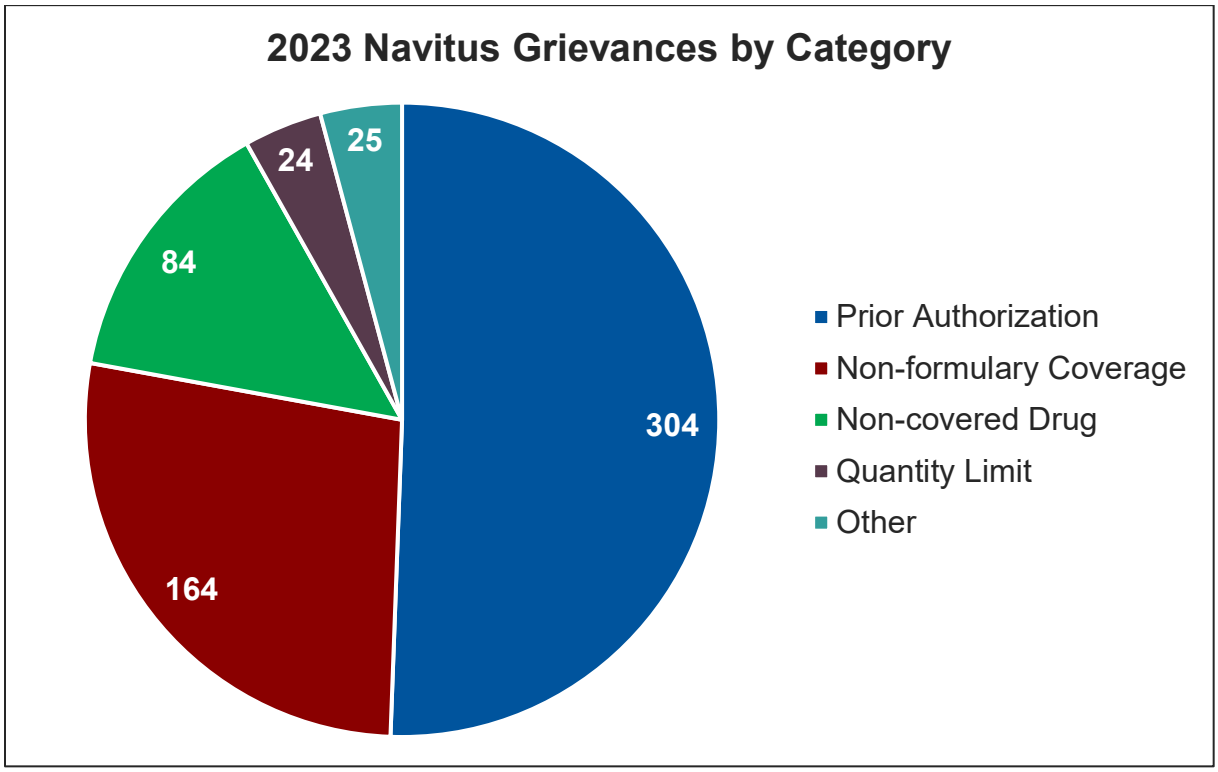
2023 Dental
Specific to dental coverage, Delta Dental had eight grievances and served 205,460 members with Uniform Dental Benefits with three grievances each for plan providers and grievances related to non-covered benefits, and one each for cost sharing and one for out of network providers.

2023 Employee Reimbursement Account Appeals
Optum, the administrator for our ERA program (which includes flexible spending , dependent day care , health savings , and parking/transit accounts), had 323 grievances for 30,417 members, a decrease of 66 grievances from 2022. Enrollment and eligibility grievances were the most common grievance type, with 270 grievances and an overturn rate of 84%. A large portion of these grievances were related to members rescinding their applications for enrollment, incomplete documentation needed to complete enrollment, or requests for late enrollment. Unsubstantiated claim appeal was the second-highest type, with 52 grievances. These members are given the ETF Unsubstantiated Business Debt Appeal process after completing the grievance process at Optum. If the outcome of this review is unfavorable, the member may request an ETF administrative review.

2023 Pharmacy Benefit Grievances
In 2023, Navitus received 605 grievances, an increase of 91 from 2022. Consistent with prior years, the most common types of pharmacy benefit grievances were for:

- Prior authorization (304).
- Non formulary drugs (164).
- Non-covered drug (84).
- Quantity limit (24).

Navitus overturned 268 grievances in 2023. The overturn rate for pharmacy benefit grievances dropped to 44% in 2023, from 49% in 2022. 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 such as anti-obesity 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 updated and available via the Navitus and ETF website. Below is a chart depicting Navitus grievances by category.



Independent Reviews

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 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 2023, ETF was notified of 67 external review requests from members in traditional health plans, which is an increase of 17 reported in 2022. The IROs

overturned the plan decision in 15 cases and upheld the plan decision in 47 cases. There were five cases in which the IRO determined the member's request was not eligible for 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, OS staff continue 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, the account executive is notified of the need for corrective action.

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

Attachment A: Health Plan Grievances Per 1,000 Members

Attachment A: Grievances Per 1000 Members by Health Plan