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Correspondence Memorandum

Date: May 7, 2025

To: Group Insurance Board

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

Subject: 2024 Health Plan and Pharmacy Benefit Manager 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 2026 open enrollment online materials.

2024 Plan Grievances
Below is a summary of the annual grievance data reported to ETF by all plans participating in Group Health Insurance Program (GHIP), excluding the Well Wisconsin Program. GHIP is defined as including wellness, health, pharmacy, uniform dental, and ERA 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 (IR) that appear later in the report, it is beneficial to keep in mind that in 2024 there were 245,000 members and dependents insured by health plan vendors and pharmacy benefit manager, which is comparable to 2023 membership. Uniform Dental Benefits also covers 209,000 members.

The total number of health plan grievances reported in 2024 was 1,559, up from 2023 with 1,390 grievances reported, or an increase of 169 grievances. The most common types of grievances in 2024 related to denials of coverage for services considered not medically necessary (657), non-covered benefits (243), and prior authorization denials (176). Specific to dental coverage, Delta Dental had nine grievances.

Of the 1,559 grievances filed, 847 were either resolved in favor of the member or resulted in a compromise. This is a 54% overturn rate and a decrease in overturns from

Pamela L Henning

Reviewed and approved by Pam Henning, Assistant Deputy Secretary
Electronically Signed 05/02/2025

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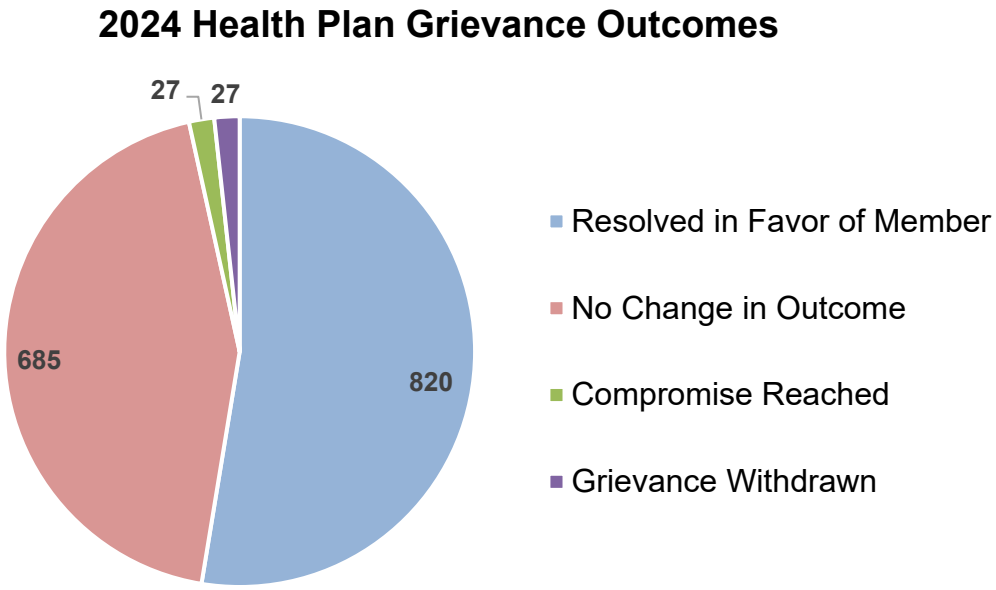
2023 with 58%. High overturn rate demonstrates the value of members working with their health plan on resolving benefit issues.

The trend of an increase in non-covered benefits due to medical necessity and contract exclusions, as well as prior authorization denials, indicate that health insurance companies are managing member care and services more closely than in the past, resulting in an increase in these grievance types. We will continue to educate these members on their grievance and IR rights to advocate for benefits coverage.



2024 ERA Grievances
Optum, the administrator for the ERA program (which includes Flexible Spending Accounts, Dependent Day Care Accounts, Health Savings Accounts, and Parking/Transit), served 33,800 enrollees and had 195 grievances in 2024. This is a decrease of 128 grievances compared to 2023. Enrollment and eligibility grievances were the most common grievance type, with 182 grievances and an overturn rate of 91%. A large portion of these grievances were related to members rescinding their applications for enrollment, incomplete enrollment documentation, and requests for late enrollments due to missing a life event deadline.

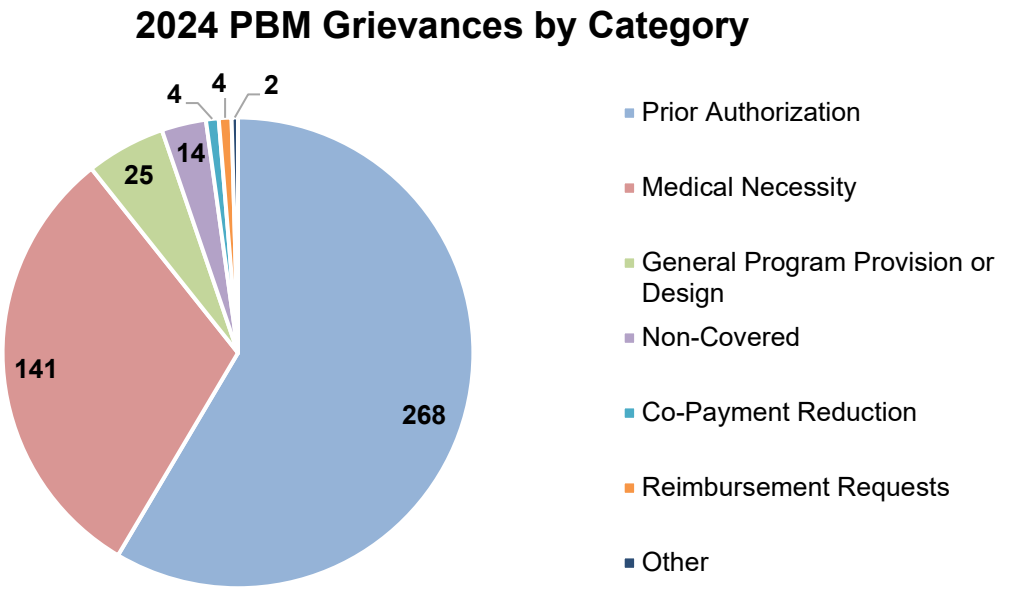
Unsubstantiated Claim (UC) appeals were the second-highest type, with 13 grievances. These members have the Unsubstantiated Business Debt Appeal process available to them at Optum. After that process, members may use the ETF Administrative Review process, which starts with an Ombudsperson review of their case. The decrease in UC grievances in 2024 indicates improved communication to members at the end of the

benefit year regarding the need for substantiation of claims and payroll deductions in January for outstanding UC, thus helping avoid appeals by members.

2024 Pharmacy Benefit Grievances
In 2024, Navitus received 458 grievances, a decrease of 147 from the 605 filed in 2023. Consistent with prior years, the most common types of pharmacy benefit grievances were for:

- Prior authorization denials (268)
- Not medically necessary denials (141)
- General program provision or design (25)

Navitus overturned 228 grievances in 2024. The overturn rate for pharmacy benefit grievances increased to 50% in 2024, from 44% in 2023. High overturn rates reinforce the importance of members utilizing the pharmacy benefit manager (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 websites.



2024 Independent External Reviews
To be eligible for independent external review (IER), 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. These include 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 IER within five business days. In 2024 there were 157 requests for IERs by State of Wisconsin (SOW) members. This is an increase of 90 reported in 2023. The IERs overturned the plan decision in 32 cases, upheld the plan decision in 122 cases, compromised on one case, and two cases were declined for IER. Ombudsperson Services (OS) continues to work with the Office of Strategic Health Policy (OSHP) on educating plans on their contractual obligation to report IER requests by SOW members.

OS monitors plan grievance decision letters to ensure members are receiving appropriate external review rights, ETF Administrative Review rights, and that Vendors are utilizing the correct ETF contract citations. When deficiencies are found with a plan, their account executive is notified of the need for corrective action. Vendors are required to send ETF a redacted version of the IER outcome (to preserve member privacy) for any GHIP members who complete the IER. These external review outcomes will be shared with the OSHP to help improve the GHIP by learning about procedures and medications that are being approved or denied by IERs and to gain a better understanding of how our benefits may provide or limit access to care.

Looking Ahead

We look forward to continued education of our vendors regarding the types of cases that are appropriate referrals to OS and how we can be used as a resource or member advocate. In addition, we will collaborate with OSHP to educate vendors and members, as needed, on Proof of Claim provision language changes for the 2026 benefit year. Discussion of examples of what ETF considers extenuation circumstances will help make this miscellaneous provision of the contract more understandable for the vendors and members.

Staff will be available at the meeting for questions or comments.

Attachment A: 2024 Grievances by Health Plan, per 1,000 members

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