ANNUAL GRIEVANCE REPORT GUIDANCE DOCUMENT

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8/19/2024

Attachment 1 - Definitions

Grievance - any written dissatisfaction with the provision of services or claims practices of an insurer that is expressed to the insurer by, or on behalf of, an enrollee.

Grievant – individual that filed the grievance. This may be an insured or another individual who filed the grievance on behalf of the insured, such as a parent or other relative, a health care provider, or another representative of the insured.

Resolution Codes

"Approved" - original decision overturned or otherwise resolved as grievant requested.
"Denied" - original decision or company position upheld.
"Compromise" - original decision partially overturned.
"Withdrawn" - grievant requests grievance be withdrawn prior to company beginning its review.

Average Monthly Enrollment- average monthly number of covered lives (including dependents) for all in-force policies during all or part of the current reporting year.

Total Policies Written - number of new policies issued during reporting year.

Direct Premium Earned -the premium collected by an insurance company for the portion of a policy term that has expired. Note: do not include Medicaid premium.

Product Type (for the purpose of the grievance reporting form)

"MSP" - Medicare Supplement Insurance Plans
"HMO" - Plans issued by insurers licensed as Health Maintenance Organizations – this product type should include grievances related to point-of-service (POS) and exclusive-provider organization (EPO) plans
"LSHO" - Plans issued by insurers licensed as limited service health organizations
"PPP" - Preferred Provider Plans
"HBP" - Health Benefit Plans – This product type should include all health insurance policies not considered HMO, LSHO, Med Supp, or PPPs. Grievances related to Dental-only and vision-only plans that are not issued by LSHO insurers, limited benefit and short-term plans should be included in the HBP product type.

Attachment 2 – Using the Grievance Reporting Application

Tips to Assist in Completing the Annual Grievance Report (26-007)

- Use Chrome browser.
- The Grievance Report Instructions provide a list of the things you will need to complete the report form and other information regarding submitting the report. The Instructions are available at https://oci.wi.gov/Pages/OCIForms/26-007Intro.aspx.
- The Annual Grievance Report should include all grievances received from or on behalf of individuals covered by policies that were issued in Wisconsin.
- If your company has active business in a product type that has not been assigned, please send an email to ocimrreports@wisconsin.gov. Provide the legal name of your company, the NAIC CoCode, and the product type that needs to be assigned.
- If your company no longer has any active business in a product type that it has been assigned and does not plan to begin marketing that product type, please contact us at the email below so that we can update our records.
- For information regarding the Wisconsin Market Regulatory Reports and Forms application, please reference the procedures document.

Review Reports prior to Submitting to Ensure Accuracy

The examiners noted that the coverage year 2023 reports were often rejected because the reports contained incorrect data and noted that some insurers had made the same errors in several previous years' reports.

Section 632.83, Wis. Stat., and s. Ins 18.06, Wis. Adm. Code, require all health benefit plans (HBPs), health maintenance organizations (HMOs), limited service health organizations (LSHOs), and preferred provider plans (PPPs) to submit annual reports to the commissioner. We remind insurers that it is the responsibility of the insurer to verify that all data is accurate **prior** to submitting the grievance report to OCI. A pattern of submitting reports with inaccurate information is potentially a violation of Wisconsin insurance law, and the matter will be reviewed for administrative action and/or forfeiture.

Attachment 3 – Tips on Completing the Annual Grievance Report Form

- The examiners noted that there appears to be some confusion regarding the use of the resolution code "withdrawn". There should be very few grievances with a "withdrawn" resolution. An insurer is required to investigate and resolve each grievance it receives.

  The "withdrawn" resolution should only be used if the insured or the insured's authorized representative requests that it be withdrawn **prior** to the insurer beginning its investigation of the grievance.

- All grievances, including those related to the quality of care provided by plan providers, must be included in the grievance report. We understand that there may be a different review process due to the confidentiality protections in state and federal peer review laws. However, a member who files a grievance regarding a plan provider's care has the right to meet with the grievance committee to explain the issue and must receive a resolution letter.

- During 2023, the examiners reviewed the prior five years of grievance reports to establish benchmarks to assist in analyzing grievance reports. Two benchmarks were chosen for 2023 reports from HMO plans: an overturn resolution rate that exceeds 45% of the total grievances and the percentage greater than 8% of plan administration vs benefit denial grievances. A high overturn resolution rate could indicate that the insurer does not have adequate procedures in place to process claims and other coverage requests. A high percentage of plan administration grievances could indicate inadequate customer service.

  The examiners will continue reviewing grievance reports to determine whether additional benchmarks may assist in analysis for HMO plans and for other plan types. As additional data is reviewed, the benchmarks may be adjusted every several years.

- As noted in the previous bullet point, a high overturn resolution rate could indicate that the insurer does not have adequate procedures in place to correctly process initial claims and other benefit requests. The examiners found grievance reports in all plan types that reported more overturned resolutions than upheld resolutions. OCI expects insurers to address high overturn rates and to identify and address any other trends found in its review of its grievance reports.

Attachment 4 – Tips for Standardized Log

- Column C – Source of Grievance –This response should be limited to: Insured, Provider, Authorized Representative or OCI.
- Column D Plan Type – This response is limited to: EPO, HMO, POS, PPP, MSP, LSHO, Dental, Vision, Limited Benefit, Short Term or HBP.
- Column F Expedited? – The response should be "Yes" if the grievance was expedited or "No" if reviewed under the standard process.
- Column I – Meeting date – If the grievance is resolved prior to the meeting, this is the date that the grievance documents were provided to the grievance committee. Note that the grievant has the right to choose to attend or participate in the grievance meeting regardless of whether the grievance was previously resolved.
- Column K – Extension Requested? –The response should be "yes" if the insurer requested an extension or "no" if no extension was requested.
- Column M – Category Qualifier
    - The response should provide specific information regarding the grievant's request, such as the insured's health condition or the health procedure being requested (e.g. heart medication, mammogram, diabetes). The qualifier should not repeat or provide a synonym of the grievance category.
    - For grievances reviewed under 45 CFR 156.122, the category is DRG category; the category qualifier should be "Formulary – ACA".
    - For grievances involving contraceptive services, the category is PVS; the category; qualifier should be "Contraceptive Services".
    - For grievances involving coverage of mental health/substance use disorder services, the category qualifier should be "Mental Health".
- Column O – **NOTE**: Resolution Qualifier will be mandatory beginning in CY2024.
- All Dates – Should be MM/DD/YYYY
    - If there is no applicable date (for example, no acknowledgement letter was sent because the grievance was expedited), the response should be "NA".