State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

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OFFICE OF THE ATTORNEY GENERAL

Submitted to the Governor and the General Assembly

Fiscal Year 2012

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I. Executive Summary

The Health Education and Advocacy Unit (the "HEAU") of the Office of the Attorney General's Consumer Protection Division submits this annual report on the implementation of the Health Insurance Carrier Appeals and Grievances Law[1] (the "Appeals and Grievances Law") as required by the Maryland Insurance Article §15-10A-08 and the Maryland Commercial Law Article §13-4A-04. Section 15-10A-08(b)(1) of the Maryland Insurance Article requires the HEAU to annually publish a summary report on the grievances and complaints filed with or referred to a carrier, the Commissioner of the Maryland Insurance Administration (the "MIA"), the HEAU, or any other federal or State government agency or unit during the previous fiscal year. Section 15-10A-08(b)(2) of the Maryland Insurance Article also requires the HEAU to evaluate the effectiveness of the internal grievance process and complaint process available to members, and to include in its annual summary report the results of this evaluation and any proposed changes that the HEAU considers necessary.

This report covers grievances and complaints filed with or referred during State Fiscal Year 2012, beginning July 1, 2011 and concluding on June 30, 2012.

This report (1) summarizes the Appeals and Grievances Law, (2) discusses how health insurance carriers, the MIA, and the HEAU implement the Appeals and Grievances Law, (3) summarizes grievances and complaints handled by carriers, the MIA and the HEAU, and (4) provides additional information about HEAU activities.

II. Overview of the Appeals and Grievances Process

State Law

In 1998, the General Assembly enacted the Appeals and Grievances Law to provide patients a process for appealing their health insurance carriers'[2] medical necessity "adverse decisions." All carriers must establish a grievance process that complies with the Appeals and Grievances Law. The Appeals and Grievances Law established guidelines that carriers must follow in notifying patients of denials, establishing appeals and grievances processes, and notifying members of grievance decisions.

In 2000, the General Assembly enacted Chapter 371[3] that expanded the grievances process to include the right to appeal contractual "coverage decisions." As a result, patients in Maryland who have coverage from a State-regulated plan can challenge any decision by a carrier that results in the total or partial denial of a covered health care service. In 2011, the General Assembly enacted Chapters 3 and 4[4], each of which expanded the definition of "coverage

[1] Md. Code Ann., Insurance §15-10A-01 through §15-10A-10.

[2] The Appeals and Grievances Law defines "carrier" as all authorized issuers that provide health insurance in the State, nonprofit health service plans, health maintenance organizations, and dental plans, that offer a health benefit plan subject to regulation by the State.

[3] Md. Code Ann., Insurance §15-10D-01 through §15-10D-04.

[4] Chapters 3 and 4 made other changes to processes and rights under the Appeals and Grievances Law that became effective July 1, 2011. Accordingly, the summary of the Appeals and Grievances Law in this report may be different from the summary in previous reports.

decisions" to include a carrier's decision that someone is ineligible for coverage or a carrier's decision that results in the rescission of an individual's coverage. As a result, effective July 1, 2011, patients in Maryland can challenge any decision by a carrier that results in the total or partial denial of a covered health care service, the denial of eligibility for coverage, or the rescission from coverage. This report, therefore, reflects for the first time specific data and statistics for ineligibility denials or rescissions of an individual's coverage.

As amended, Maryland law established two very similar processes for patients to dispute carrier determinations, one for carriers' denials that proposed or delivered health care services are not or were not *medically necessary* ("adverse decisions") and another for carriers' determinations that result in the *contractual exclusion* of a health care service ("coverage decisions").

Federal Law

Under the Patient Protection and Affordable Care Act (the "ACA"), consumers have the right to appeal health plans' decisions rendered after March 23, 2010. Through guidance and regulations issued in July 2010[5] and July 2011[6], the U.S. Departments of Health and Human Services ("HHS"), Labor, and the Treasury standardized internal claims and appeals and external review processes for group health insurance plans and health insurance issuers offering coverage in the group and individual markets. Under the regulations, consumers have the right to:

1. information about why a claim or coverage has been denied and how they can appeal that decision;

2. appeal to the insurance company to conduct a full and fair review of its decision (*internal appeals*); and

3. take their appeals to an independent third-party review organization ("IRO") for review of the insurer's decision (*external review*) for claims that involve medical judgment (including but not limited to those based on the plan's requirements for (a) medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer, or (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

In 2011, HHS deemed the Maryland laws dealing with internal and external review as meeting the "strict standards" included in the July 2010 rules. Accordingly, Maryland continues to implement the Appeals and Grievances Law as described below.

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[5] http://www.cms.gov/cciio/resources/Regulations-and-Guidance/index.html#External Appeals; 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 23, 2010).

[6] 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 26, 2011).

III. Phases of the Appeals and Grievances Process

For both adverse decisions and coverage decisions, the appeals and grievances process starts when a patient receives notice from the carrier that the carrier has rendered an adverse decision or coverage decision. Carriers must provide patients with a written notice that clearly states the basis of the carrier's adverse or coverage decision and that the HEAU is available to mediate the dispute with the carrier or, if necessary, help the patient file a grievance or appeal. The notice must also inform the patient that an external review of the decision is available through the MIA or other external reviewer following exhaustion of the carrier's internal process. Patients may file a complaint with the MIA or other external reviewer prior to exhausting the internal grievance process only when there is a compelling reason.

After receiving the initial denial, the patient[7] may contest the determination through the carrier's internal grievance or appeal process. After receipt of the grievance or appeal, the carrier has 30 working days to review adverse decisions involving pending care and 45 working days for already rendered care. For coverage decisions, the carrier has 60 working days after the date the appeal was filed with the carrier to render a decision. The carrier must issue a written decision to the patient at the conclusion of this internal process.

If the carrier's final decision is unfavorable, the patient may file a complaint with the MIA or other external reviewer for an external review of the carrier's adverse decision or coverage decision involving medical judgment. Other coverage decisions of carriers regulated by the MIA can be appealed to the MIA under State law. The ACA did not extend external review rights for coverage decisions based strictly on contractual language unrelated to those requiring medical judgment.

IV. Carrier Reporting

The Appeals and Grievances Law requires carriers to submit quarterly reports to the MIA on the number of adverse decisions issued and the number and outcomes of internal grievances the carriers handled. The MIA then forwards these reports to the HEAU for inclusion in this report. Although the carriers' quarterly report data provides some basic insight into the carriers' internal grievance processes, its usefulness is limited by several factors, including:

- The carriers are only required to report information on medical necessity denials (*adverse decisions*). Accordingly, the State does not collect comprehensive information about the types and outcomes of contractual exclusions of health care services (*coverage decisions*) rendered by the carriers.

- The carriers do not report data about each individual grievance. The carriers divide their data into medical service categories and report on the limited data within each category. As the categories are not standardized, reporting and categorizing may vary significantly from one carrier to another, making it difficult to compare one carrier's data to that of another.

[7]Throughout this report, we refer to the rights of patients during the appeals and grievances process. The Appeals and Grievances Law also gives health care providers and, pursuant to Chapters 3 of 4 in 2011, the member's representative, if any, the right to file appeals and grievances on behalf of patients.

- The diagnosis and procedure information carriers report is incomplete. Carriers must report diagnostic or treatment codes for a limited number of complaints. Although the limited data provides basic evaluative information, complete reporting would provide a more valuable tool in analyzing grievance data.

- Carriers are not required to identify the grievances that involved the MIA or the HEAU. As this information is not present, it is impossible to check the cases reported by carriers against the data recorded by the MIA or the HEAU to verify the consistency of data reporting.

- An analysis of the number of adverse decisions and grievances compared to enrollee numbers cannot be performed as carriers are not required to report membership or enrollee numbers.

Carrier Statistics FY 2012

In addition to the highlights below, charts providing statistical detail from the data submitted by the carriers appear on pages 10-18 of this report.

1. Carriers reported 60,394 adverse decisions in FY 2012, 26,384 fewer adverse decisions than reported in FY 2011. The carriers administratively reversed 332 of these adverse decisions, or less than 0.6%.

2. Carriers reported that in FY 2012 consumers filed half the number of grievances filed in FY 2011. In FY 2011, consumers filed 9,572 grievances. In FY 2012, consumers filed only 4,712 internal grievances; a decrease of 4,860 grievances. Because carriers are not required to report membership numbers, it cannot be determined if the decrease in grievances filed represents a decrease in overall membership.

3. Overall, during the internal grievance process carriers altered their original adverse decisions in 59% of the grievances reported in FY 2012. Carriers overturned their adverse decisions in 55% of the grievances and modified their determinations in 4% of the grievances filed. This represents a decrease in the percentage of grievances carriers altered since FY 2011, when carriers reported changing 68% of their adverse decisions.

4. Outcomes from carriers' internal grievance processes vary significantly based on the type of service in dispute. These trends have remained constant during the past four years, with carriers more often reversing adverse decisions related to physicians and other health care providers than adverse decisions involving mental health care and durable medical equipment. There are two changes in the trend that are worth noting. First, the percentage of grievances carriers overturned or modified in FY 2012 decreased, significantly in many instances, across all service types except home health and pharmacy where carriers increased the number of grievances they overturned or modified and inpatient hospitalization and mental health which remained steady. Accordingly, carriers upheld their adverse decisions more in FY 2012 across the majority of service types than in FY 2011. Second, carriers reduced most between FY 2011 and FY 2012 the percentage of PT, OT and Speech Therapy

services they overturned or modified. Carriers reduced the percentage of PT, OT and Speech Therapy grievances they overturned or modified between FY 2011 and FY 2012 from 46% to 32%. Similarly, carriers decreased the percentage of emergency room grievances they overturned or modified from 59% in FY 2011 to 47% in FY 2012.

5. Adverse decisions involving mental health/substance abuse services continue to be significantly less likely to be overturned or modified than other types of health care services. For FY 2012, carriers reported an overturned or modified rate of only 23% for mental health and substance abuse.

V. Maryland Insurance Administration (MIA)

The MIA has regulatory oversight of insurance products offered in Maryland. In 1998, the Appeals and Grievances Law was enacted by the General Assembly to provide a fair process for resolving disputes regarding the medical necessity of a proposed or delivered health care service (See Title 15, Subtitle 10A of the Insurance Article). Until July 1, 2011, the Appeals and Grievances law applied only to individuals with insured health benefits. However, because of the ACA expansion of external appeal rights, effective July 1, 2011, the Department of Budget and Management for the State of Maryland voluntarily elected to use the Maryland Insurance Administration's external review process to provide external review for the State of Maryland's self-funded employee health benefit plan.[8]

When the MIA receives a written complaint from a member, a member's authorized representative, a health care provider or facility, the MIA will review it to determine if the complaint raises issues subject to the Appeals and Grievances Law. If the Appeals and Grievances Law applies, the MIA confirms that the insurance carrier's internal grievance process has been fully exhausted because the law requires the process to be fully exhausted prior to the MIA's involvement in the matter unless there is a compelling reason for the MIA to act prior to the exhaustion process. If the carrier's internal process has been exhausted or if there is a compelling reason to bypass the internal grievance process, within 5 working days of receipt of the complaint, the MIA will contact the carrier in writing requesting a written response to the complaint. Unless an extension request from the carrier is granted by the MIA, the carrier shall respond to the MIA within 7 working days of receipt of the complaint (with the exception of a complaint that involves an emergency issue that must be resolved within 24 hours of receipt of the complaint), and the carrier must respond to the MIA by providing medical and claims information (including the health benefit contract) pertinent to the complaint and either uphold, reverse, or modify its denial. When the MIA does not have jurisdiction over the complaint or the carrier's internal grievance process has not been exhausted, the MIA shall refer the complainant to the HEAU so that the member, the member's authorized representative, a health care provider or facility can be assisted through the carrier's internal grievance process or external process as applicable.

[8] While the MIA only conducts the external review for individuals with insured health benefits and the Department of Budget and Management for the State of Maryland, with the exception of grandfathered plans, the ACA mandates external review processes for all group health insurance plans and health insurance issuers offering coverage in the group and individual markets.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then the MIA will prepare the case for review. As part of the preparation, the MIA will contact the complainant and the carrier in writing, giving them a deadline for submitting additional documentation to be considered in the review as applicable. Once the MIA receives the proper documentation, the case is copied and forwarded to an Independent Review Organization (IRO) for medical necessity reviews. In selecting an IRO, the MIA ensures that the IRO has an appropriate board certified physician available to review the case. Upon receipt of the case from the MIA, the IRO then transmits the case to it's expert reviewer who researches and reviews the case, renders an opinion, and transmits the opinion back to the IRO. The IRO, in turn, conducts a quality review of the expert reviewer's opinion. For medical necessity reviews, the MIA asks the IRO to respond to specific questions as set forth in a cover letter attached to the complaint. The IRO will orally inform the MIA of the expert reviewer's determination and follow-up with the written determination via facsimile and first class mail. If the IRO reviewer's recommendation is to overturn, uphold or modify the carrier's denial, the MIA may accept this recommendation and base its final closing letter on the professional judgment of the IRO reviewer. The complainant is notified of the outcome by telephone and/or mail. The MIA also forwards a copy of the IRO's medical opinion and invoice to the carrier via facsimile and U.S. mail. In all instances, the carrier that is the subject of the complaint must pay the expenses of the IRO selected by the MIA. Hearing rights contesting the decision vary based on the plan and the outcome.

Maryland law requires that the MIA make a final decision on complaints within 45 calendar days of receipt of the written complaint. However, the MIA can extend cases for an additional 30 working days if information requested by the MIA has not been received. For emergency or compelling cases, the MIA will conduct an expedited external review, completing the above process within 24 hours of receipt of the complaint. A hotline number (800-492-6116) is available 24 hours a day, seven days a week to respond to these emergency or compelling cases.

MIA Statistics FY 2012

MIA-provided data is reported on the charts and tables contained on pages 19-25 of this report. The data reflects only those cases where a disposition has been rendered; pending cases are not reported.

In addition to the data reflected in the charts and tables, the MIA-reported data reveals:

1. The MIA's Appeals and Grievances Unit received 860 complaints in FY 2012. After reviewing these complaints, the MIA determined that 432 involved adverse decisions issued by health insurance carriers the MIA regulated.

2. The MIA referred 99 complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 333 complaints in which complainants challenged the carrier's grievance decision. The MIA modified or reversed the carrier's grievance decision or the carrier reversed its own grievance decision during the course of the MIA's

investigation in 204 cases (61%). Conversely, the MIA upheld 129 (39%) of the carrier decisions.

VI. Health Education and Advocacy Unit (HEAU)

The Maryland General Assembly established the HEAU in 1986. The HEAU was designed to assist health care consumers in understanding health care bills and third party coverage, to identify improper billing or coverage determinations, to report billing and/or coverage problems to appropriate agencies, including the Consumer Protection Division's Enforcement Unit, and to assist patients with health equipment warranty issues. Based upon HEAU's successful efforts in these areas, the General Assembly selected the HEAU to be the State's first-line consumer assistance agency when it passed the Maryland Appeals and Grievances Law. Since then, other states have used the HEAU as a model when creating their own consumer assistance programs and the HEAU has been cited as a model in Congressional testimony in support of early federal efforts to promote programs that would assist health care consumers, including the Health Care Consumers Assistance Fund Act of 2001. In late 2010, the HEAU received a Consumer Assistance Program grant from the Office of Consumer Information and Insurance Oversight to expand the Unit in anticipation of greater appeal numbers, to provide enrollment assistance to consumers prior to the opening of the Health Insurance Exchanges, and to conduct outreach activities about the Unit.

The Appeals and Grievances Law requires carriers to notify patients that the HEAU is available to assist them in mediating and filing a grievance or appeal of an adverse decision or coverage decision. The notice must also include the HEAU's address, telephone number ((410) 528-1840), facsimile number ((410) 576-6571) and email address (heau@oag.state.md.us). The HEAU conducts outreach programs to increase awareness of consumer rights under the Appeals and Grievances Law and the assistance the HEAU can provide consumers.

When the HEAU receives a request for assistance, the HEAU gathers basic information from the carriers related to the services or care denied. Specifically, the HEAU asks the carrier to provide a copy of the insurance contract provisions or the utilization review criteria upon which the carrier based the denial and to identify precisely which provision or criteria the patient failed to meet. Carriers must provide requested information to the HEAU within 7 working days from the date the carrier received the request.[9] The HEAU also gathers information about the patient's condition from the patient and his or her provider to determine if the patient meets the criteria established by the health plan and assess whether the denial is incorrect. The HEAU presents this information to the carrier for reconsideration of the denial. Many complaints are resolved during this information exchange process. If not resolved, the HEAU will prepare and file a formal written grievance or appeal with the carrier on behalf of the patient.

If, at the conclusion of the internal appeals and grievances process, the carrier continues to deny coverage for the care, the HEAU prepares an external appeal of the carrier's decision. The HEAU forwards the case to the MIA or other external entity with a copy of all relevant medical and insurance documentation and the HEAU monitors the outcome of the external review.

[9] Md. Code Ann., Commercial Law §13-4A-02.

HEAU Statistics FY 2012

The HEAU Appeals and Grievances data[10] is reported in the charts and tables contained on pages 26-44 of this report. The data reflects both medical necessity and contractual denials. Because newly filed cases contain incomplete data, the cases reported are those cases the HEAU closed during FY 2012.

The HEAU closed 2,125 cases in FY 2012. Of those cases, 851 were appeals and grievances related cases. Not all of the 851 appeals and grievances cases filed with the HEAU were mediated. Many consumers, or other persons, file complaints but an authorization to release medical records form, which the HEAU requires to mediate the case, is never completed. Other complaints are filed for the record only or are referred to another more applicable agency. Of the 851 appeals and grievances cases the HEAU closed during FY 2012, 626 or 74% involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 626 cases involved more than one carrier.

1. Of the 626 appeals and grievances cases (634 carriers involved) the HEAU mediated during FY 2012, 402 (63%) related to MIA-regulated plans.

2. Of the 626 cases the HEAU mediated during FY 2012, 34% were adverse decision (*medical necessity*) cases, 44% were coverage decision (*contractual exclusion*) cases, and 22% were eligibility denials.

3. The HEAU mediation process resulted in carriers overturning or modifying 53% of the appeals and grievances cases. The carriers overturned or modified 53% of the adverse decision cases, 49% of the coverage decision cases, and 61% of the eligibility denial cases.

4. In cases filed against carriers subject to MIA review, the HEAU mediation efforts resulted in carriers changing their decisions 62% of the time. For non-regulated plans, the HEAU efforts resulted in carriers changing their decisions 39% of the time.

5. In FY 2012, the HEAU formally assisted 82 consumers in identifying available health insurance options.

6. In FY 2012, the HEAU assisted patients in recovering or saving more than $ 2 million dollars, over $1.5 million of which pertained to appeals and grievances cases.

[10] This report does not contain detailed data related to the outcomes of cases handled by HEAU unrelated to the Appeals and Grievances Law; some general complaint numbers and categories are reported for informational purposes.

VII. Appendix

Carrier Cases
Adverse Decisions, Grievances and Outcomes

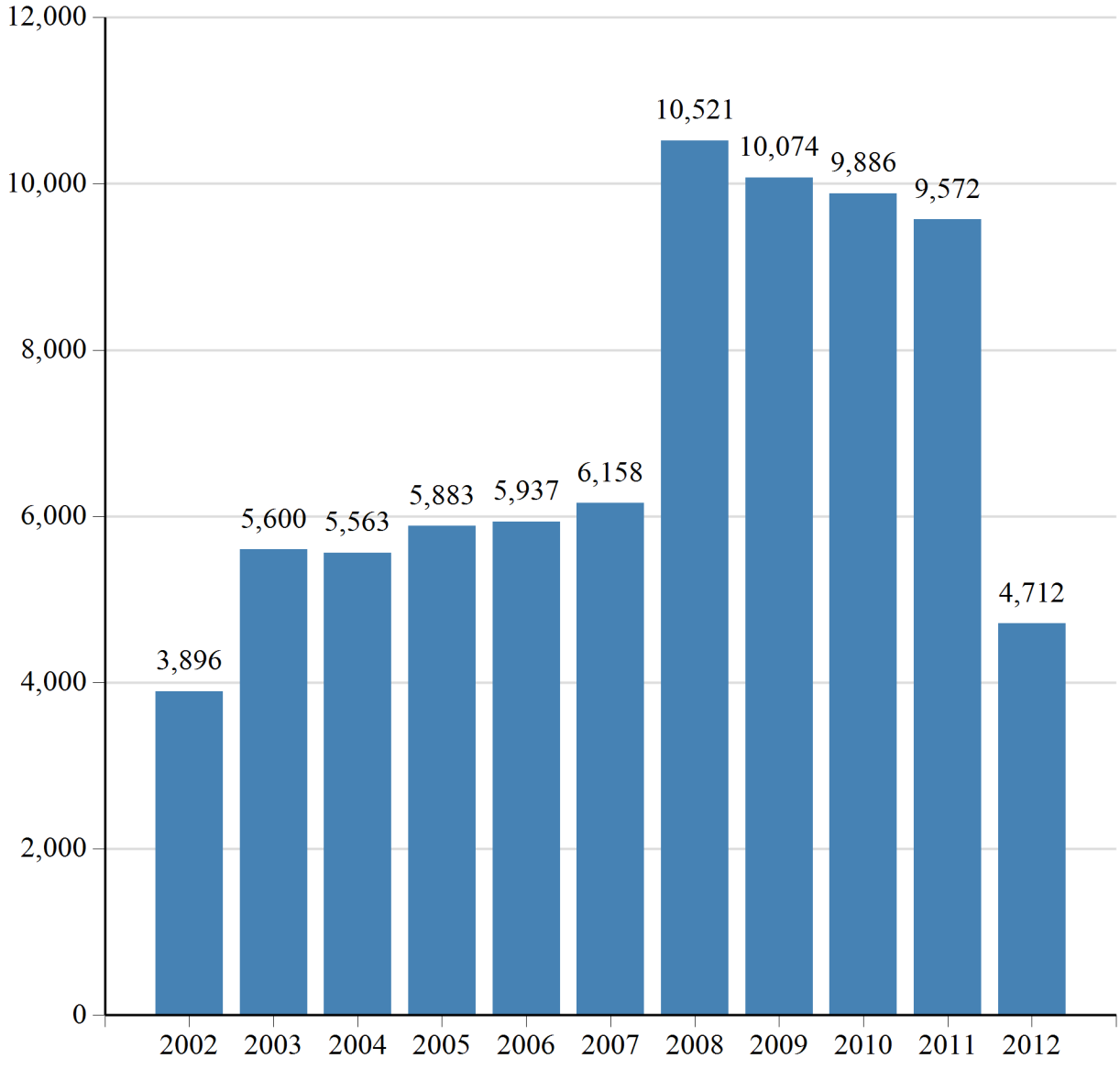
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Aetna Dental Inc.	411	0	0	0%	0%
Aetna Health Inc. (a Pennsylvania corporation)	730	17	53	62%	38%
Aetna Life Insurance Company	947	19	91	63%	37%
American General Life Insurance Company of Delaware	0	0	1	0%	100%
Ameritas Life Insurance Corp.	114	0	42	50%	50%
CareFirst BlueChoice, Inc.	10,706	0	948	29%	71%
Carefirst of Maryland, Inc.	4,549	0	518	17%	83%
CIGNA Dental Health of Maryland, Inc.	307	0	0	0%	0%
CIGNA Health and Life Insurance Company	21	0	1	100%	0%
Connecticut General Life Insurance Company	1,609	1	124	63%	37%
Coventry Health Care of Delaware, Inc.	1,855	95	526	71%	29%
Dental Benefit Providers of Illinois, Inc.	10	0	32	50%	50%
Golden Rule Insurance Company	21	0	5	80%	20%
Graphic Arts Benefit Corporation	1	0	36	64%	36%
Group Dental Service of Maryland, Inc.	18,754	0	252	43%	57%
Group Hospitalization and Medical Services, Inc.	8,240	0	621	26%	74%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Guarantee Trust Life Insurance Company	1	0	2	50%	50%
Guardian Life Insurance Company of America	577	2	177	37%	63%
Humana Dental Insurance Company	42	0	3	33%	67%
John Alden Life Insurance Company	5	0	0	0%	0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	841	5	127	54%	46%
Kaiser Permanente Insurance Company	116	0	20	65%	35%
Lincoln National Life Insurance Company	25	0	3	33%	67%
Madison National Life Insurance Company, Inc.	0	0	1	100%	0%
MAMSI Life and Health Insurance Company	99	0	0	0%	0%
MD-Individual Practice Association, Inc.	4,085	0	380	47%	53%
Metropolitan Life Insurance Company	332	181	15	7%	93%
Nationwide Life Insurance Company	4	0	0	0%	0%
New York Life Insurance Company	5	0	0	0%	0%
Optimum Choice, Inc.	2,299	0	106	57%	43%
Pan-American Life Insurance Company	0	0	1	100%	0%
Reliance Standard Life Insurance Company	9	0	1	100%	0%
Standard Security Life Insurance Company of New York	0	0	6	67%	33%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Sun Life Assurance Company of Canada	21	0	4	50%	50%
Time Insurance Company	7	0	0	0%	0%
Union Security Insurance Company	25	12	25	16%	84%
United Concordia Dental Plans, Inc.	6	0	0	0%	0%
United Concordia Life and Health Insurance Company	1,132	0	347	45%	55%
United Healthcare Insurance Company	1,889	0	167	57%	43%
UnitedHealthcare of the Mid-Atlantic, Inc.	599	0	77	82%	18%
Total	**60,394**	**332**	**4,712**	**41%**	**59%**

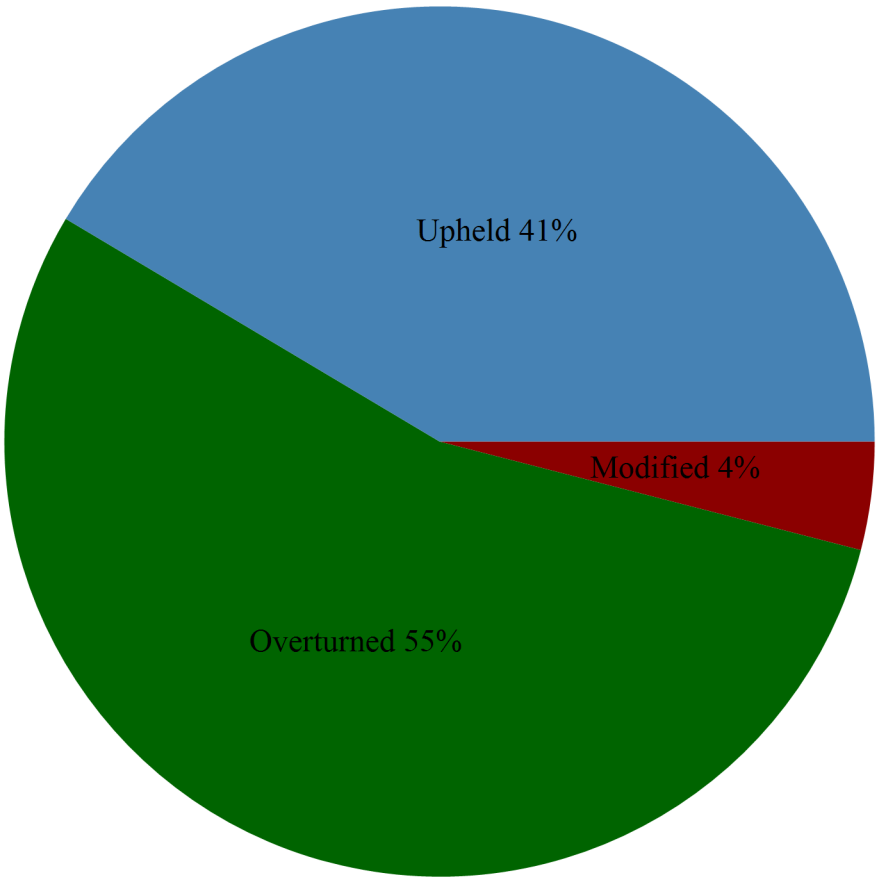
Carrier Grievances Cases
Number of Grievances Since Fiscal Year 2002

The chart below shows the history of the number of grievances filed with carriers under the Appeals and Grievances Law over the last 10 fiscal years.



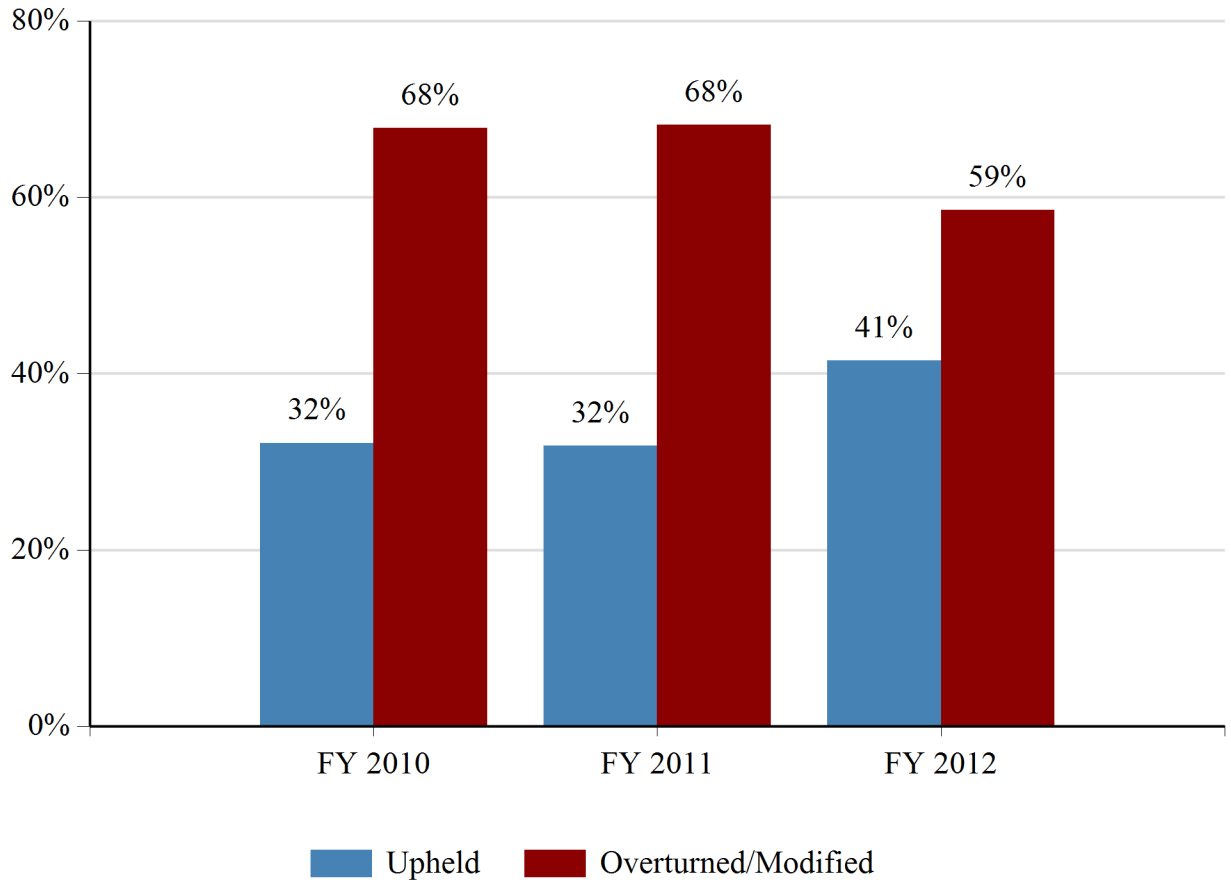
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 4,712 internal grievances filed with carriers in FY 2012, as reported by the carriers.



Carrier Grievances Cases
Three Year Comparison of Outcomes

The chart below compares the year-to-year outcomes of grievances filed with carriers, as reported by the carriers.



Carrier Grievances Cases
Types of Services

Carriers must report the types of services involved in the adverse decisions they issue and the internal grievances they receive. The table below details the types of services involved in the adverse decisions issued and internal grievances filed in FY 2012, as reported by carriers. The carriers report mental health and substance abuse services together.

Type of Service	Adverse Decisions		Grievances	
Durable Medical Equipment	2,134	3.53%	156	3.31%
Emergency Room	262	0.43%	93	1.97%
Home Health	347	0.57%	14	0.30%
Inpatient Hospital	4,209	6.97%	420	8.91%
Laboratory, Radiology	6,751	11.18%	451	9.57%
Mental Health	949	1.57%	281	5.96%
Other	181	0.30%	107	2.27%
Pharmacy	4,217	6.98%	596	12.65%
Physician	14,015	23.21%	966	20.50%
Podiatry, Dental, Optometry, Chiropractic	25,059	41.49%	1,488	31.58%
PT, OT, ST	2,140	3.54%	118	2.50%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	130	0.22%	22	0.47%
Total	**60,394**	**100%**	**4,712**	**100%**

*"Other" means cases where type of service did not fit an existing category.

Carrier Grievances Cases
Outcomes by Service Type

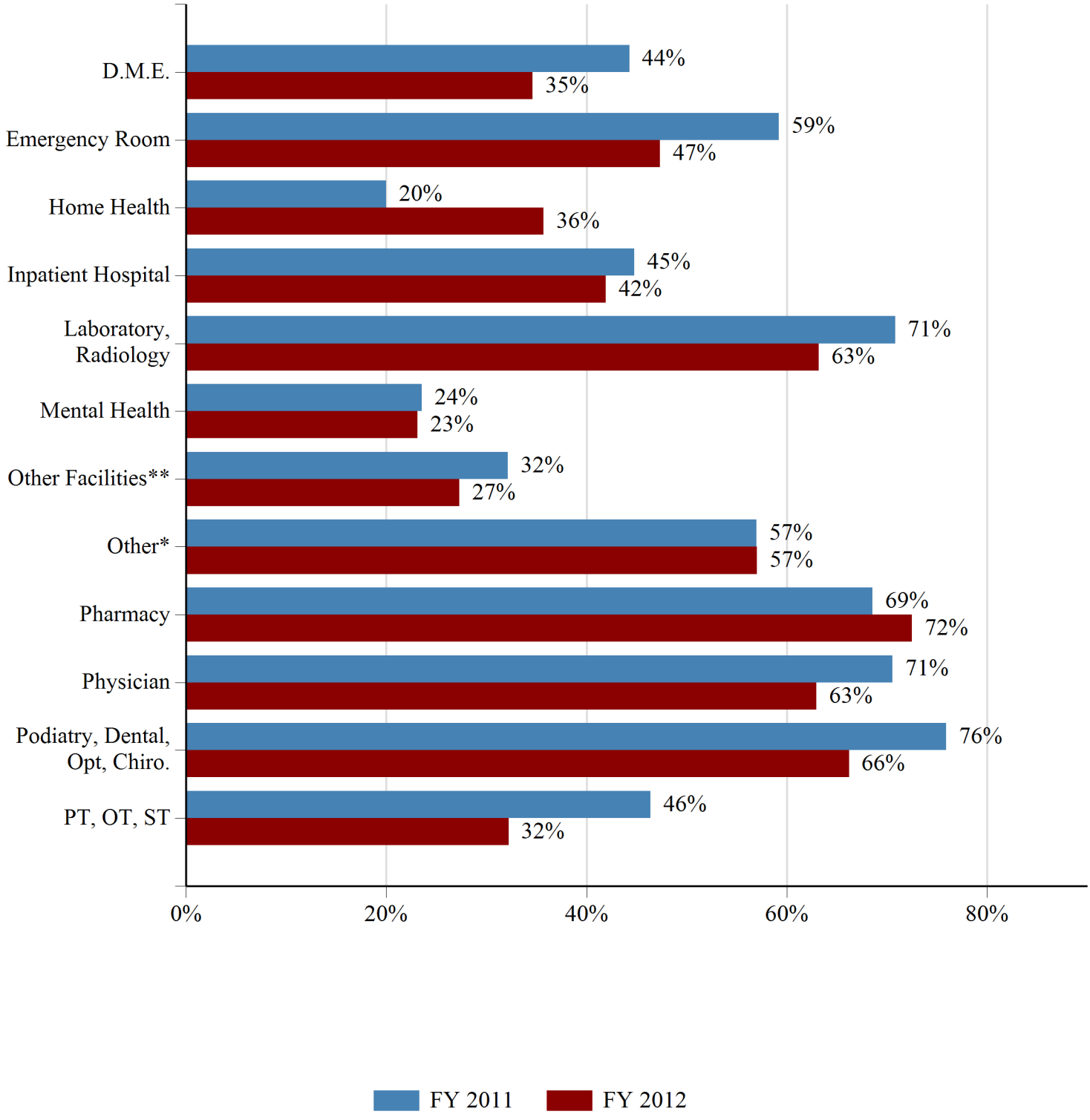
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data. Overturned or modified cases have been combined to more clearly present the data. The carriers report mental health and substance abuse services together.

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Durable Medical Equipment	156	65%	35%
Emergency Room	93	53%	47%
Home Health	14	64%	36%
Inpatient Hospital	420	58%	42%
Laboratory, Radiology	451	37%	63%
Mental Health	281	77%	23%
Other	107	43%	57%
Pharmacy	596	28%	72%
Physician	966	37%	63%
Podiatry, Dental, Optometry, Chiropractic	1488	34%	66%
PT, OT, ST	118	68%	32%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	22	73%	27%
Total	**4,712**	**41%**	**59%**

*"Other" means cases where the type of service did not fit an existing category.

Carrier Grievances Cases
Two Year Comparison by Service Type

The chart below compares the percentages of grievances carriers overturned or modified by types of services, comparing FY 2011 and FY 2012. The carriers report mental health and substance abuse services together.

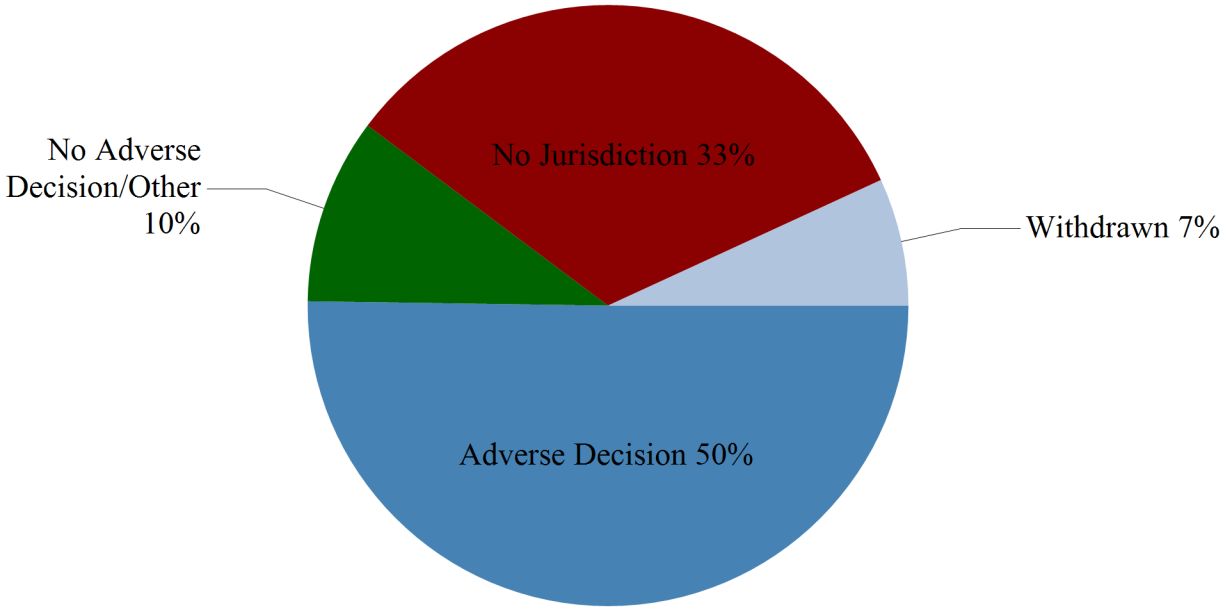


* "Other" means cases where the type of service did not fit an existing category.
**"Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.

MIA Appeals and Grievances Complaints
Initial Review of Cases

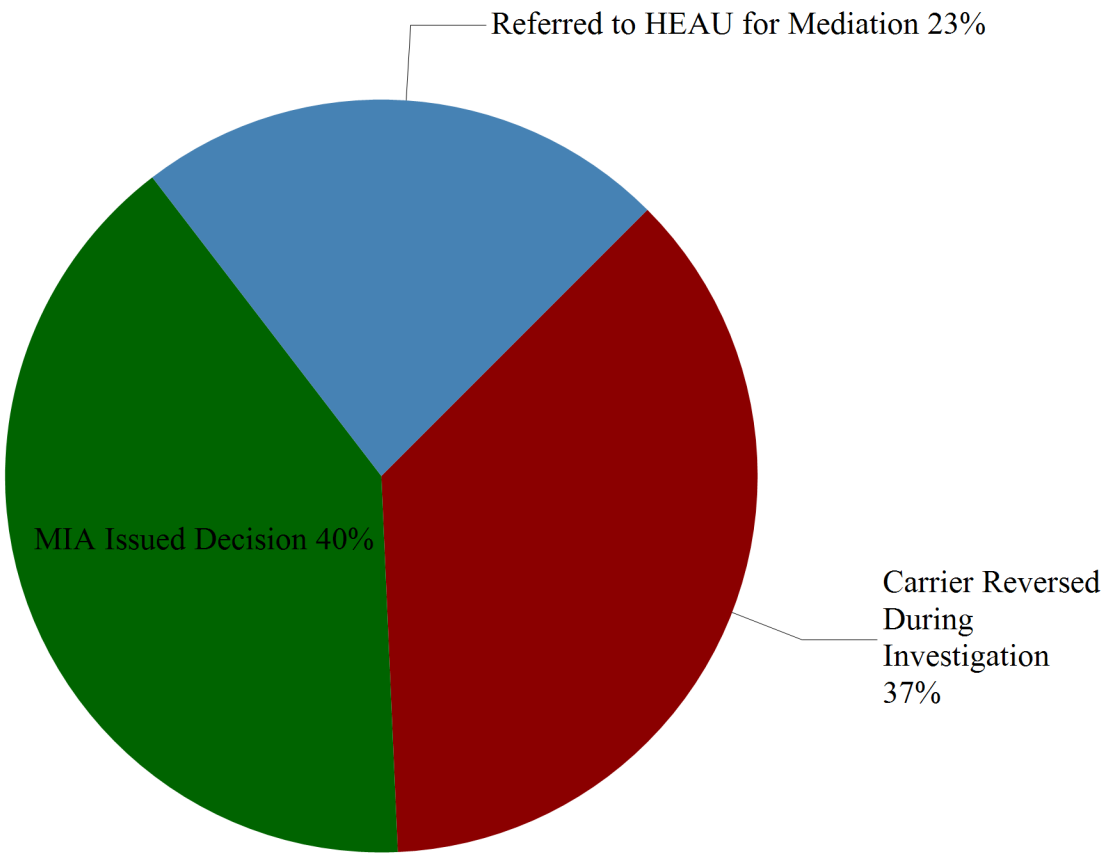
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some complaints to the MIA are withdrawn or there is not enough information to complete the review.

The chart below details the initial disposition of the 860 cases filed with the MIA's Appeals and Grievances Unit during FY 2012.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2012, the MIA determined that 432 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 99 cases to the HEAU where the patient had not exhausted the carrier's internal grievance process. The remaining cases resulted in the carriers reversing their decisions or the MIA issuing a decision. The chart below details the initial disposition of the 432 grievances the MIA reviewed during FY 2012.



MIA Appeals and Grievances Cases
Carriers and Disposition

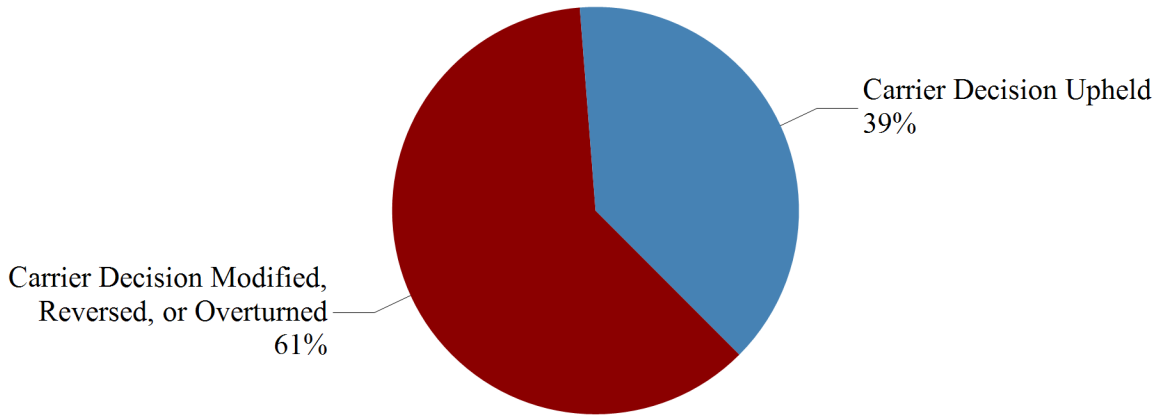
The table below details the outcomes of the 333 grievances complaints the MIA investigated during FY 2012. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	3	1	33.3%	0	0.0%	0	0.0%	2	66.7%
Aetna Health, Inc.	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
Aetna Life Insurance Company	22	11	50.0%	3	13.6%	0	0.0%	8	36.4%
APS Healthcare	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
CareFirst BlueChoice, Inc.	52	20	38.5%	3	5.8%	1	1.9%	28	53.8%
Carefirst of Maryland, Inc.	40	13	32.5%	4	10.0%	2	5.0%	21	52.5%
Cigna Dental Health of Maryland, Incorporated	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Connecticut General Life Insurance Company	10	4	40.0%	0	0.0%	0	0.0%	6	60.0%
Coventry Health and Life Insurance Company	9	3	33.3%	2	22.2%	0	0.0%	4	44.4%
Coventry Health Care of Delaware, Inc.	18	6	33.3%	4	22.2%	1	5.6%	7	38.9%
Denex Dental	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Group Hospitalization and Medical Services, Inc.	44	16	36.4%	6	13.6%	1	2.3%	21	47.7%
Guardian Life Insurance Company of America	4	2	50.0%	1	25.0%	0	0.0%	1	25.0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	11	7	63.6%	1	9.1%	0	0.0%	3	27.3%
Kaiser Permanente Insurance Company	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
MAMSI Life and Health Insurance Company	4	4	100.0%	0	0.0%	0	0.0%	0	0.0%

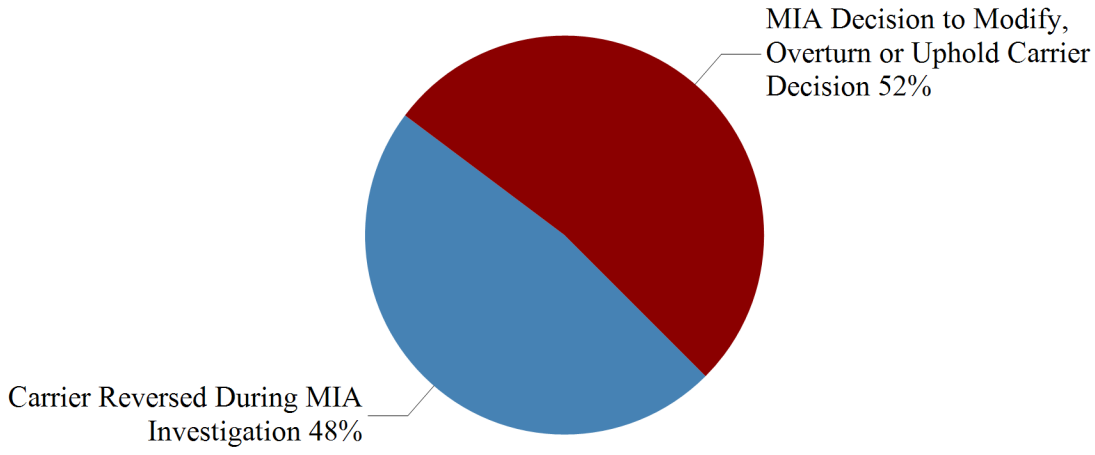
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Maryland Health Insurance Plan	17	5	29.4%	0	0.0%	0	0.0%	12	70.6%
Optimum Choice, Inc.	22	11	50.0%	5	22.7%	1	4.5%	5	22.7%
Principal Life Insurance Company	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
United Concordia Dental Plans, Inc.	3	1	33.3%	1	33.3%	0	0.0%	1	33.3%
United Concordia Life and Health Insurance Company	24	11	45.8%	1	4.2%	1	4.2%	11	45.8%
UnitedHealthcare Insurance Company	33	10	30.3%	2	6.1%	3	9.1%	18	54.5%
UnitedHealthcare of the Mid-Atlantic, Inc.	6	1	16.7%	1	16.7%	1	16.7%	3	50.0%
UnitedHealthcare Services, Inc.	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
Total	**333**	**129**	**39%**	**34**	**10%**	**11**	**3%**	**159**	**48%**

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 333 grievances the MIA investigated.

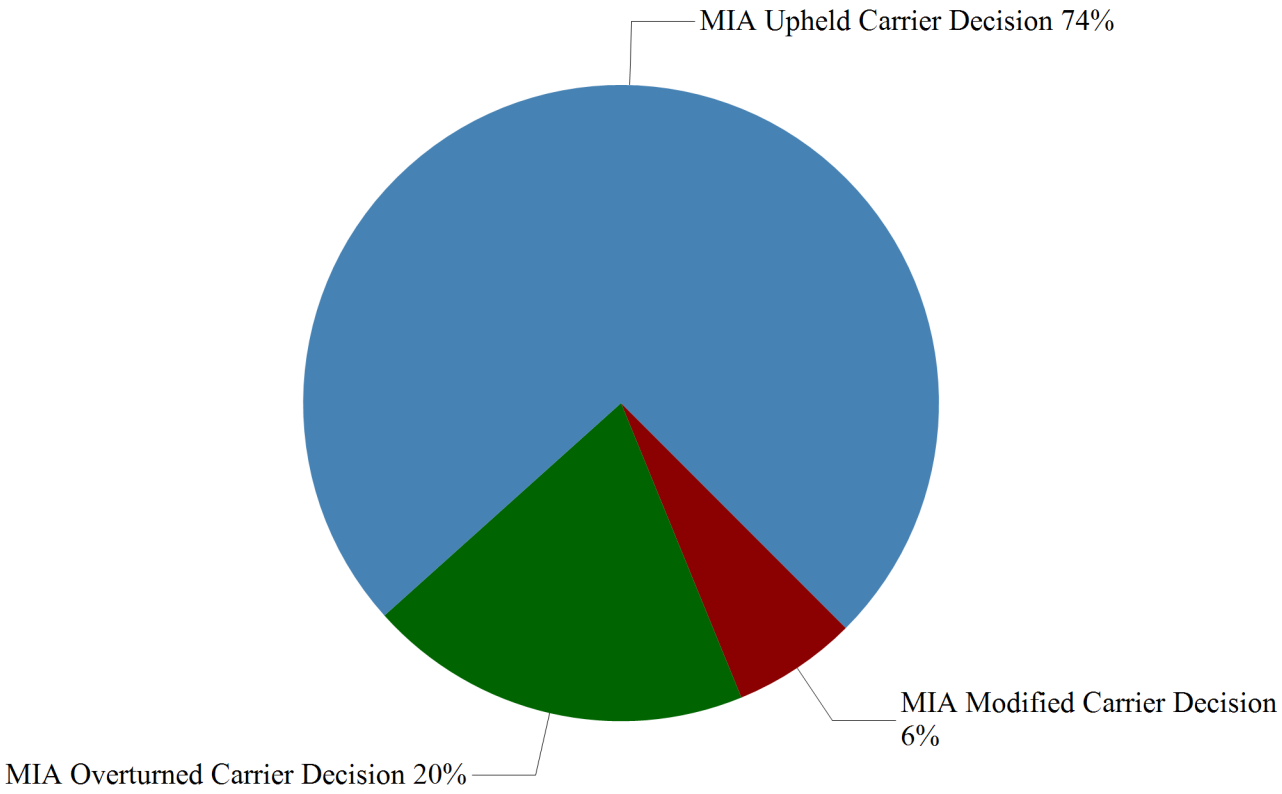


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 174 cases the MIA forwarded to an IRO for review in FY 2012.



MIA Appeals and Grievances Cases
Types of Services Denied and Outcomes

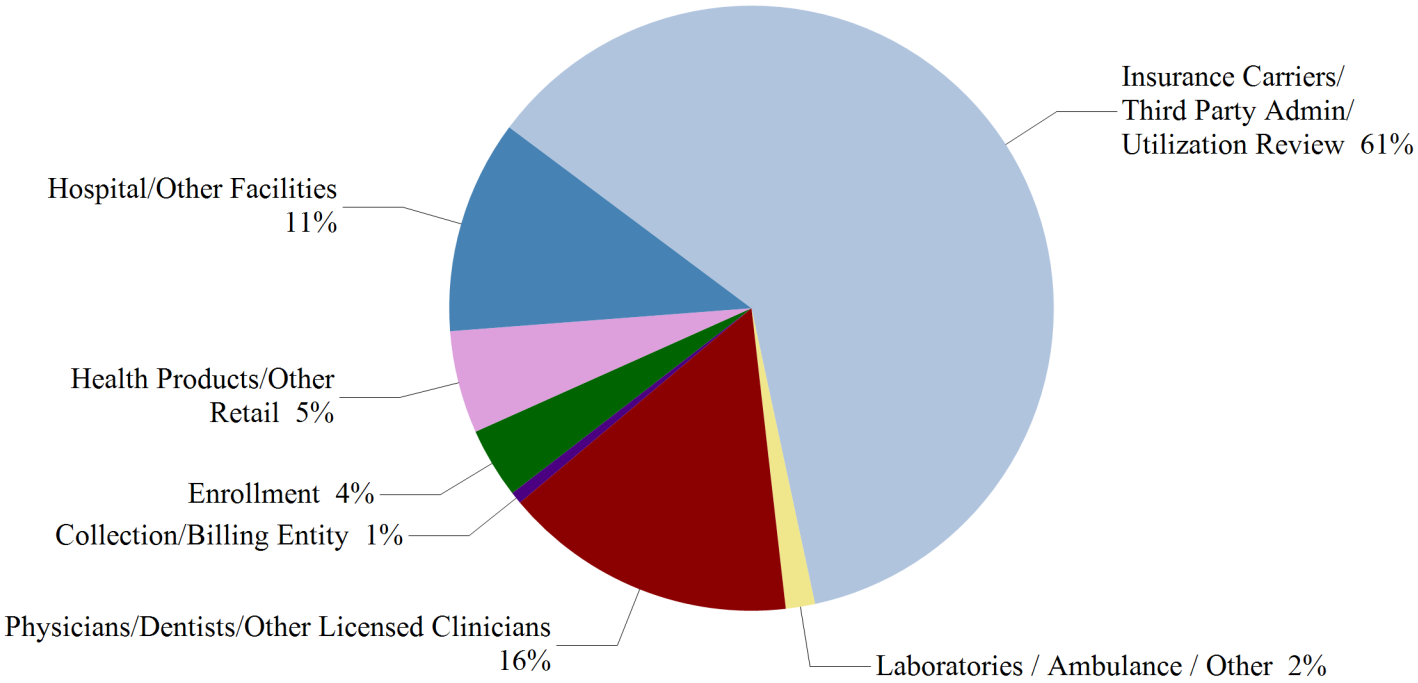
The table below identifies the types of services involved in grievances the MIA investigated during FY 2012. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Chiropractic Care Services	3	0.90%	2	67%	0	0%	0	0%	1	33%
Cosmetic	8	2.40%	4	50%	2	25%	0	0%	2	25%
Denial of Hospital Days	21	6.31%	10	48%	4	19%	1	5%	6	29%
Dental Care Services	64	19.22%	24	38%	6	9%	2	3%	32	50%
Durable Medical Equipment	12	3.60%	6	50%	1	8%	0	0%	5	42%
Emergency Room Denial	4	1.20%	0	0%	0	0%	0	0%	4	100%
Emergency Treatment Denial	1	0.30%	0	0%	0	0%	0	0%	1	100%
Experimental	38	11.41%	14	37%	4	11%	0	0%	20	53%
Eye Care Services	3	0.90%	1	33%	0	0%	0	0%	2	67%
Habilitative Service	1	0.30%	0	0%	0	0%	0	0%	1	100%
In-Patient Rehabilitation Services	2	0.60%	2	100%	0	0%	0	0%	0	0%
Lab, Imaging, Test Services	13	3.90%	6	46%	1	8%	0	0%	6	46%
Medical Food	3	0.90%	1	33%	0	0%	0	0%	2	67%
Mental Health Partial Hospitalization	1	0.30%	0	0%	1	100%	0	0%	0	0%
Mental Health/Substance Abuse (Inpatient) Services	29	8.71%	15	52%	2	7%	3	10%	9	31%
Mental Health/Substance Abuse (Outpatient) Services	7	2.10%	3	43%	0	0%	1	14%	3	43%
Morbid Obesity	1	0.30%	1	100%	0	0%	0	0%	0	0%
No Preauthorization	1	0.30%	1	100%	0	0%	0	0%	0	0%
Nursing Home Services	1	0.30%	0	0%	0	0%	1	100%	0	0%
Out-of-Network Benefits	1	0.30%	1	100%	0	0%	0	0%	0	0%
Outpatient Services	3	0.90%	2	67%	0	0%	0	0%	1	33%

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Pharmacy Services/Formulary Issues	67	20.12%	15	22%	7	10%	1	1%	44	66%
Physician Services	30	9.01%	14	47%	5	17%	0	0%	11	37%
Podiatry Services	1	0.30%	0	0%	0	0%	0	0%	1	100%
PT, OT, ST Services	9	2.70%	5	56%	1	11%	0	0%	3	33%
Retroactive Denial	1	0.30%	0	0%	0	0%	1	100%	0	0%
Reversal of Pre-Authorization	1	0.30%	0	0%	0	0%	0	0%	1	100%
Skilled Nursing Facility Care Services	4	1.20%	1	25%	0	0%	0	0%	3	75%
Transportation Services	3	0.90%	1	33%	0	0%	1	33%	1	33%
Total	**333**	**100%**	**129**	**39%**	**34**	**10%**	**11**	**3%**	**159**	**48%**

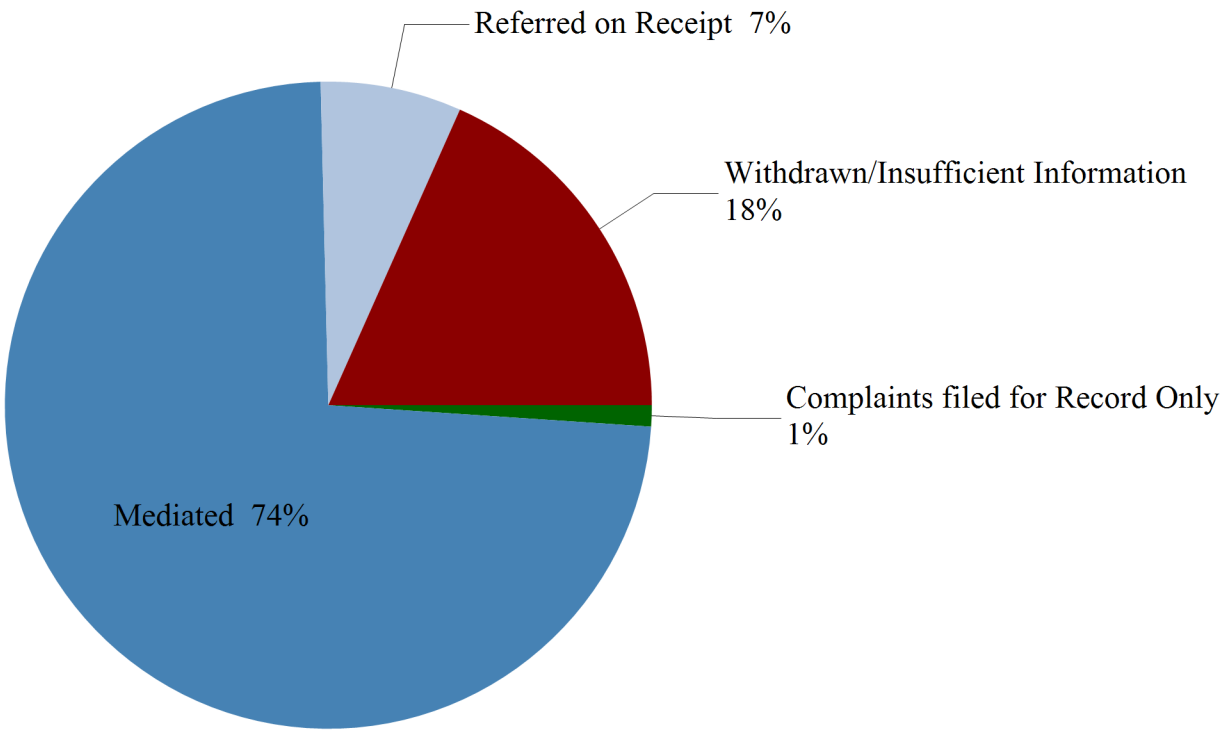
HEAU Cases
Subject of Complaints

The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but the HEAU cases also involve access to medical records, sales and service problems with health care products, and various other issues encountered in the health care marketplace. In FY 2011, the HEAU in accordance with CCIIO grant terms, began collecting data on enrollment assistance cases. These cases are noted as enrollment. The chart below shows the types of industries involved in the cases the HEAU closed during FY 2012. The HEAU closed 2,125 complaints. Some complaints were filed against more than one industry.



HEAU Appeals and Grievances Cases
Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Many consumers, or other persons, file complaints but never complete an authorization to release medical records, a form required by the HEAU to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. The chart below details the initial disposition of the Appeals and Grievances cases closed by the HEAU during FY 2012.



HEAU Mediated Appeals and Grievances Cases
Carriers, Regulatory Authority and Disposition

The table below identifies the names of the carriers and the outcomes of the Appeals and Grievances cases mediated and closed by the HEAU during FY 2012. Some complaints involve more than one carrier. Accordingly, the total number of complaints is greater than the number of total cases the HEAU mediated and closed in FY 2012.

Carrier	Total Cases	Upheld		Overturned/Modified	
Active Health Management					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Aetna US Healthcare					
State Regulated	16	9	56%	7	44%
Not State Regulated	36	31	86%	5	14%
Total Complaints	**52**	**40**	**77%**	**12**	**23%**
Amerigroup Community Care					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Anthem Blue Cross Blue Shield					
State Regulated	1	1	100%	0	0%
Not State Regulated	2	1	50%	1	50%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Anthem Blue Cross Blue Shield of Indiana					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Anthem UM Services					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
APS Healthcare Bethesda, Inc.					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
APWU Health Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
ASI					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Assurant Health					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Blue Cross Blue Shield of Illinois					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
BlueCross BlueShield of Alabama					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
CareFirst BlueChoice					
State Regulated	70	22	31%	48	69%
Not State Regulated	2	1	50%	1	50%
Total Complaints	**72**	**23**	**32%**	**49**	**68%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Carefirst of Maryland					
State Regulated	182	51	28%	131	72%
Not State Regulated	43	21	49%	22	51%
Total Complaints	**225**	**72**	**32%**	**153**	**68%**
CareFirst the Dental Network					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Catalyst Health Solutions					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
CIGNA					
State Regulated	8	7	87.5%	1	12.5%
Not State Regulated	19	12	63%	7	37%
Total Complaints	**27**	**19**	**70%**	**8**	**30%**
Cigna Behavioral Health					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CIGNA Dental					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Coventry Health Care					
State Regulated	9	7	78%	2	22%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**10**	**8**	**80%**	**2**	**20%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Delta Dental of California					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Delta Dental of Pennsylvania					
State Regulated	1	0	0%	1	100%
Not State Regulated	2	1	50%	1	50%
Total Complaints	**3**	**1**	**33%**	**2**	**67%**
Delta Dental of Rhode Island					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Express Scripts					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Golden Rule Insurance					
State Regulated	11	4	36%	7	64%
Not State Regulated	14	10	71%	4	29%
Total Complaints	**25**	**14**	**56%**	**11**	**44%**
Government Employees Health Association (GEHA)					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Graphic Arts Benefit Corporation					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Group Dental Service of Maryland					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Guardian Life Insurance Company of America					
State Regulated	2	1	50%	1	50%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**3**	**1**	**33%**	**2**	**67%**
Hagerstown Teamsters & Motor Carrier					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Highmark Blue Cross Blue Shield					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Humana Insurance Company (Dental)					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Independence Blue Cross Blue Shield					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	15	9	60%	6	40%
Not State Regulated	3	1	33%	2	67%
Total Complaints	**18**	**10**	**56%**	**8**	**44%**

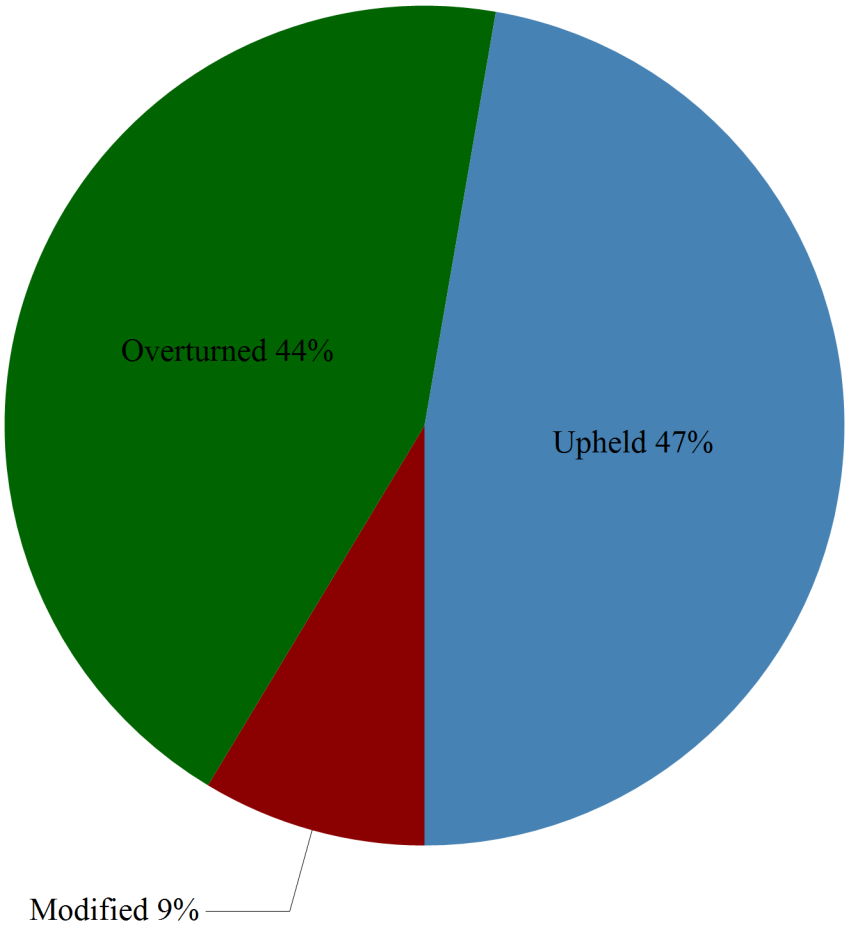
Carrier	Total Cases	Upheld		Overturned/Modified	
Magellan Behavioral Health					
State Regulated	5	3	60%	2	40%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**6**	**4**	**67%**	**2**	**33%**
Mail Handlers Benefit Plan					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Maryland Health Insurance Plan (MHIP)					
State Regulated	16	6	37.5%	10	62.5%
Total Complaints	**16**	**6**	**37.5%**	**10**	**62.5%**
MDIPA					
State Regulated	2	0	0%	2	100%
Not State Regulated	5	3	60%	2	40%
Total Complaints	**7**	**3**	**43%**	**4**	**57%**
Medicare					
Not State Regulated	3	1	33%	2	67%
Total Complaints	**3**	**1**	**33%**	**2**	**67%**
MetLife					
State Regulated	3	0	0%	3	100%
Not State Regulated	11	5	45%	6	55%
Total Complaints	**14**	**5**	**36%**	**9**	**64%**
National Claims Administrative Services					
Not State Regulated	4	3	75%	1	25%
Total Complaints	**4**	**3**	**75%**	**1**	**25%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Optimum Choice					
State Regulated	3	2	67%	1	33%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**4**	**3**	**75%**	**1**	**25%**
Preferred Care, Inc.					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Premera Blue Cross Blue Shield of Alaska					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Principal Life Insurance Company					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Security Life Insurance Company of America					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Service Benefit Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Seven Corners, Inc.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
United Behavioral Health					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
United Concordia Companies, Inc.					
State Regulated	18	14	78%	4	22%
Not State Regulated	15	9	60%	6	40%
Total Complaints	**33**	**23**	**70%**	**10**	**30%**
United Healthcare					
State Regulated	30	14	47%	16	53%
Not State Regulated	35	19	54%	16	46%
Total Complaints	**65**	**33**	**51%**	**32**	**49%**
Totals					
State Regulated	401	153	38.2%	248	61.8%
Not State Regulated	233	143	61.4%	90	38.6%
TOTALS	**634**	**296**	**47%**	**338**	**53%**

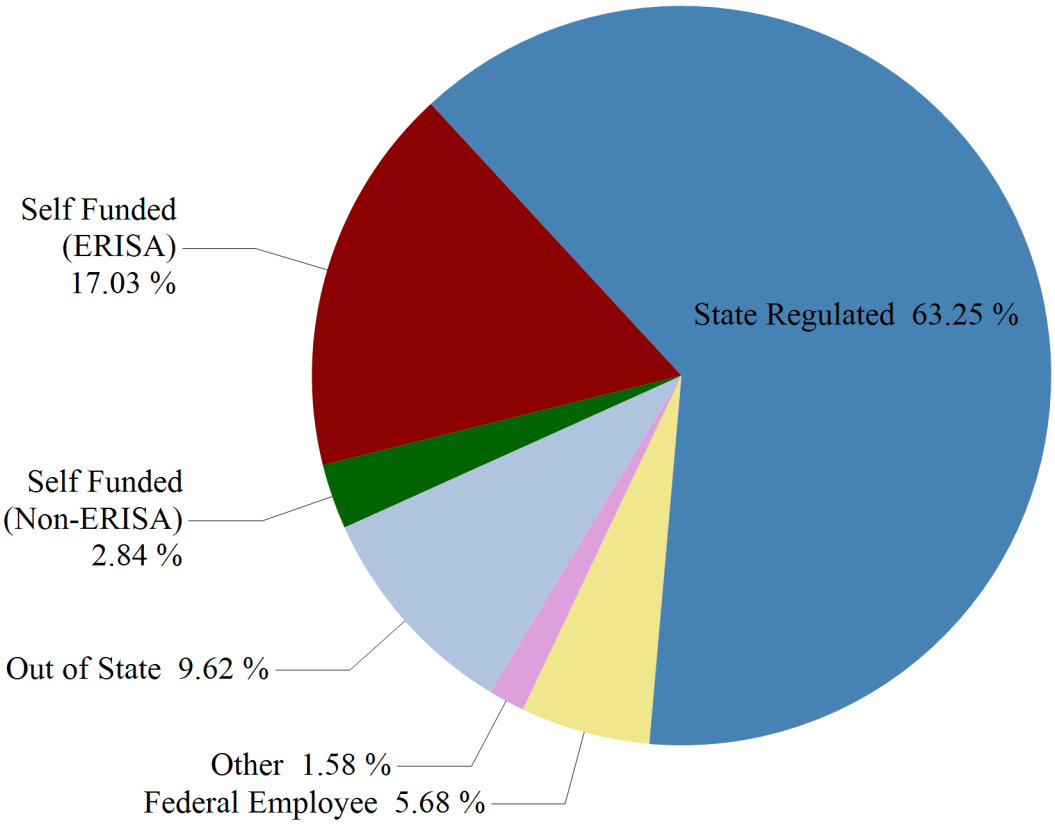
HEAU Mediated Appeals and Grievances Cases
Disposition

Carriers may uphold, overturn, or modify their decisions during the appeals and grievances process. The chart below identifies the outcomes of the Appeals and Grievances cases that the HEAU mediated and closed during FY 2012.



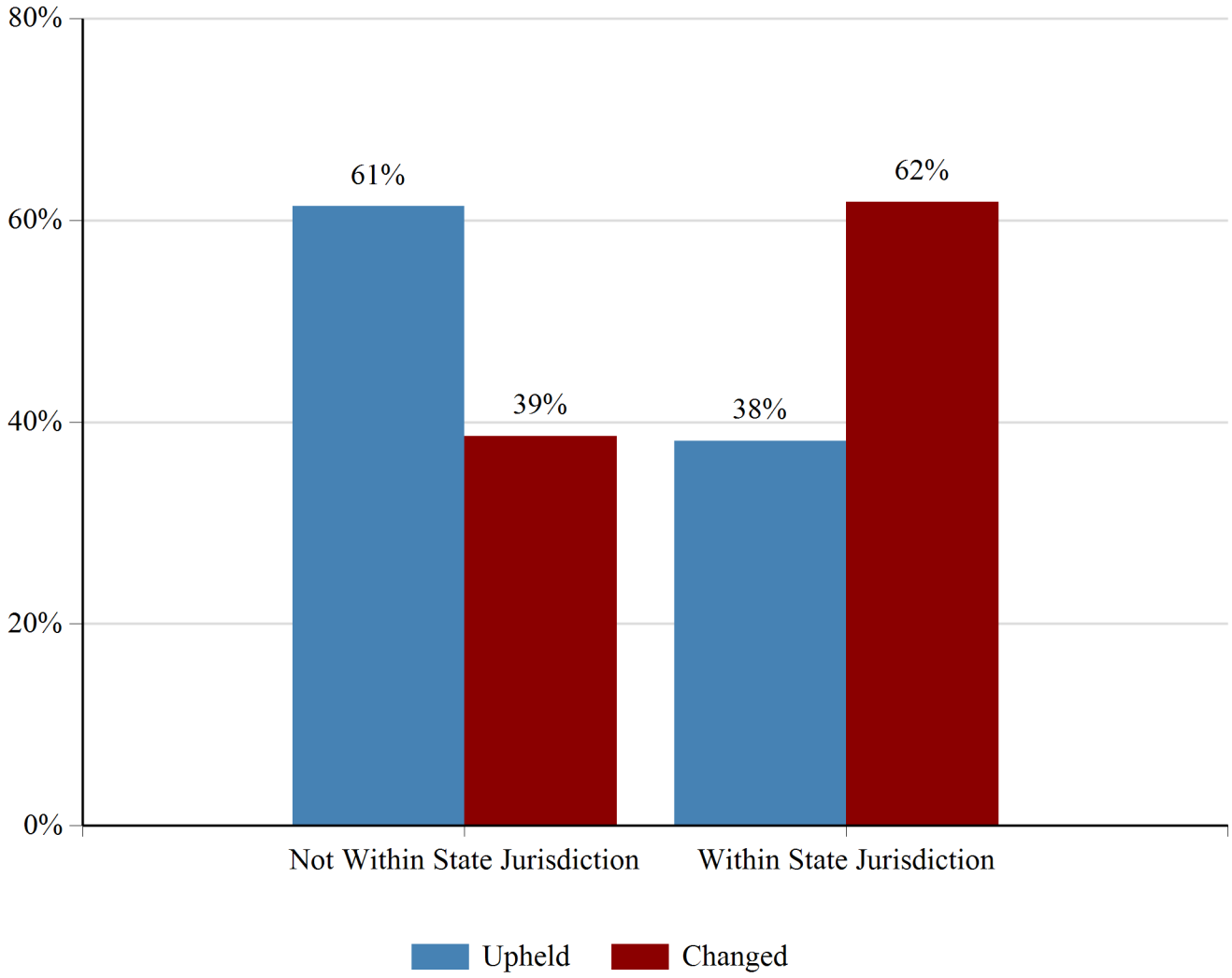
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the types of carriers involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2012.



HEAU Mediated Appeals and Grievances Cases
Outcomes Based on MIA Regulatory Authority

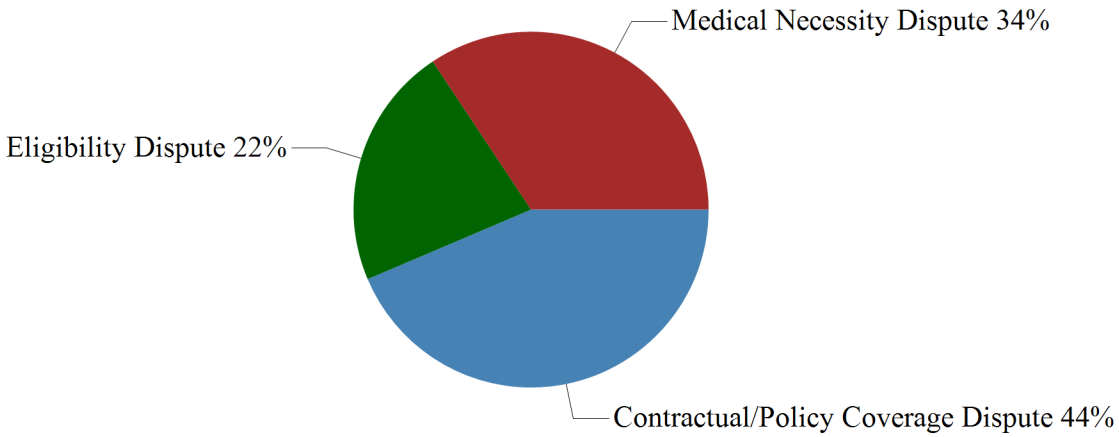
The chart below reflects the outcomes of Appeals and Grievances cases the HEAU mediated and closed during FY 2012 in relation to the MIA's regulatory authority over the carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

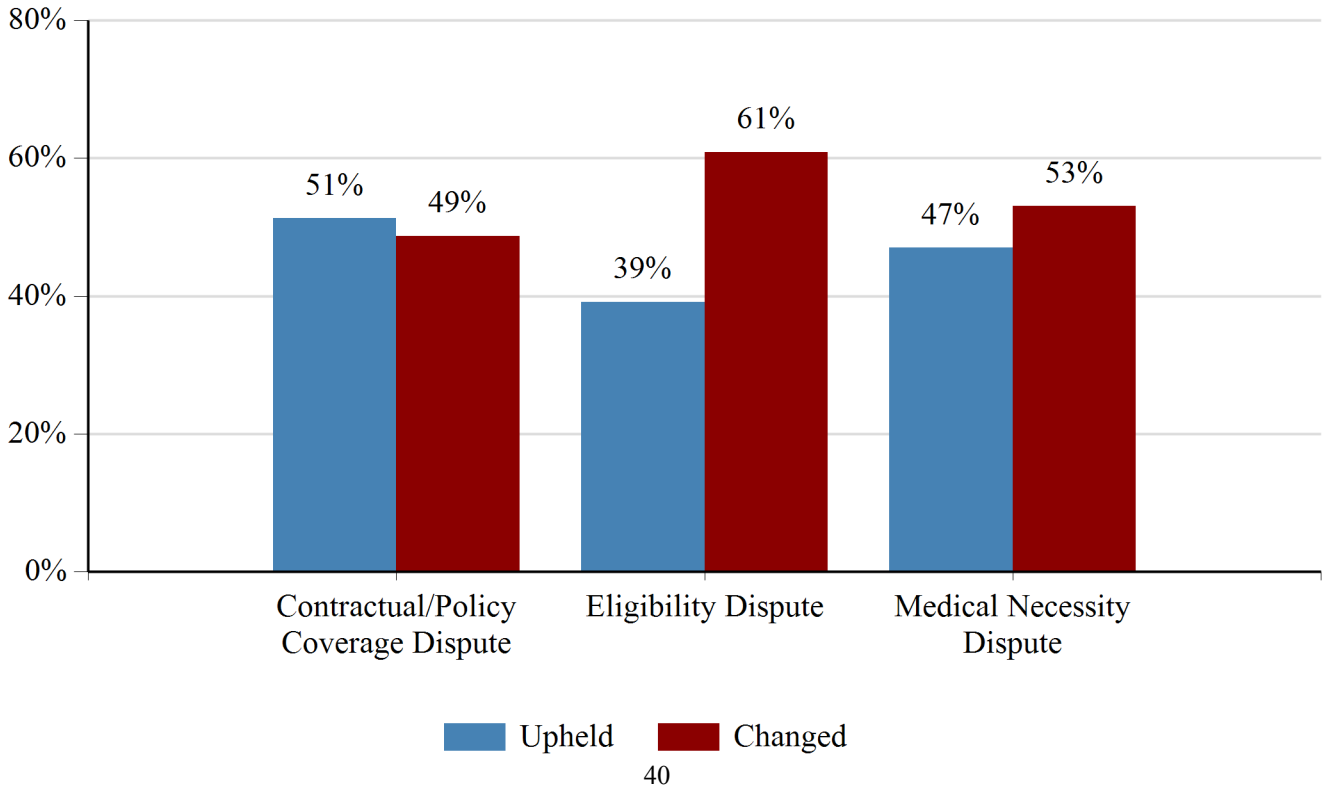
Types of Denials

The HEAU reports data on medical necessity, contractual coverage and eligibility disputes. The chart below identifies the percentages of each type of case the HEAU mediated and closed during FY 2012.



Outcomes by Denial Type

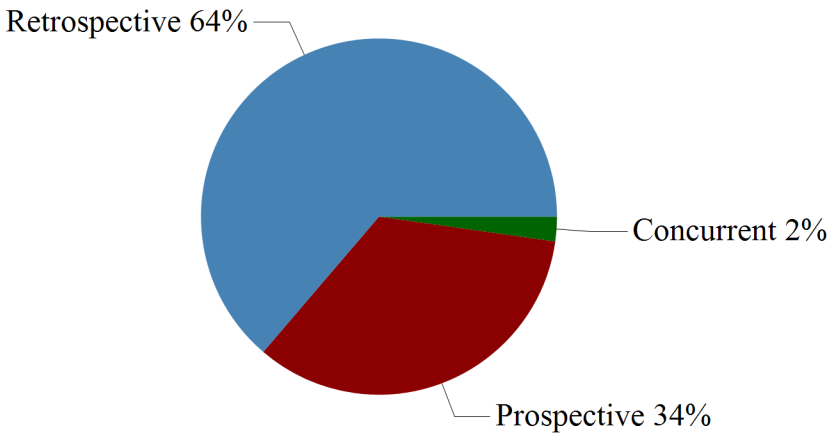
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes that the HEAU mediated and closed during FY 2012.



HEAU Mediated Appeals and Grievances Cases

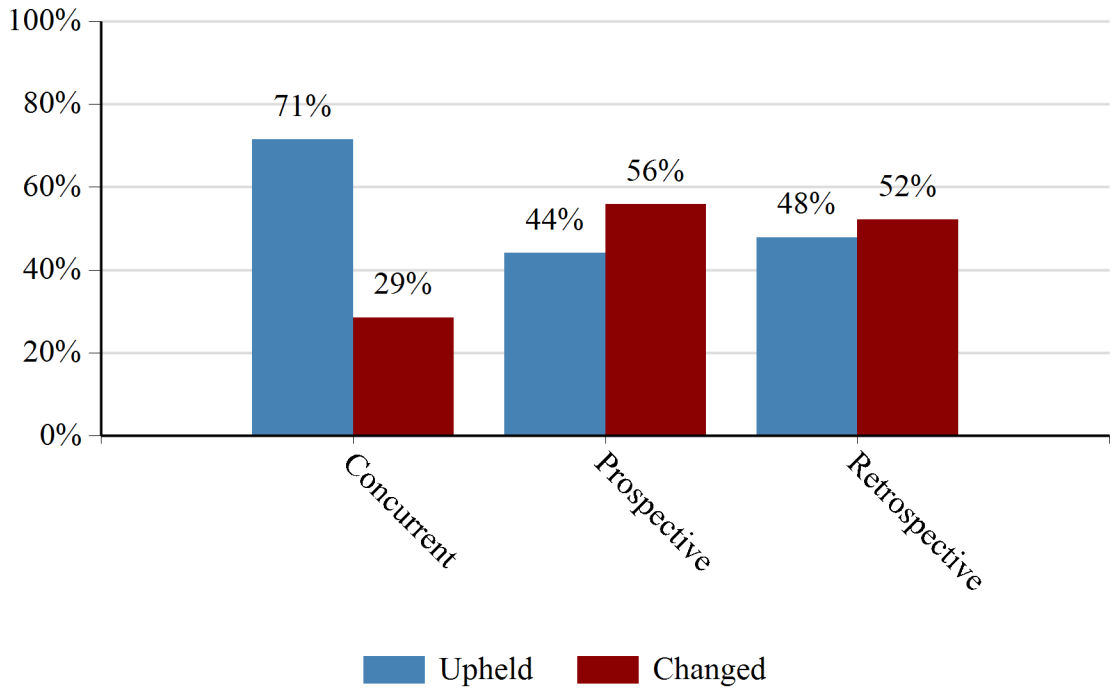
Timing of Denials

Carriers can deny coverage prior to a provider rendering a service, while a provider is rendering a service, or after a provider renders a service. The chart below identifies the percentages of the timing of carrier denials for each type of Appeals and Grievances case the HEAU mediated and closed during FY 2012. Eligibility denials are treated as prospective denials.



Outcomes by Timing of Denials

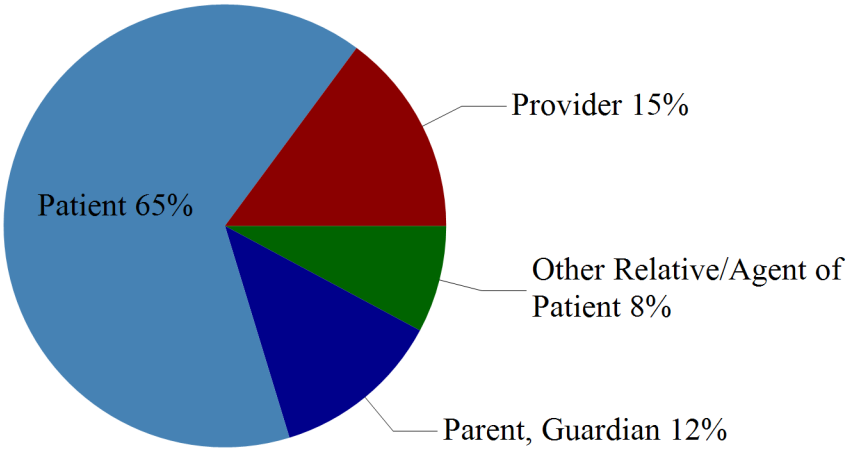
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2012 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

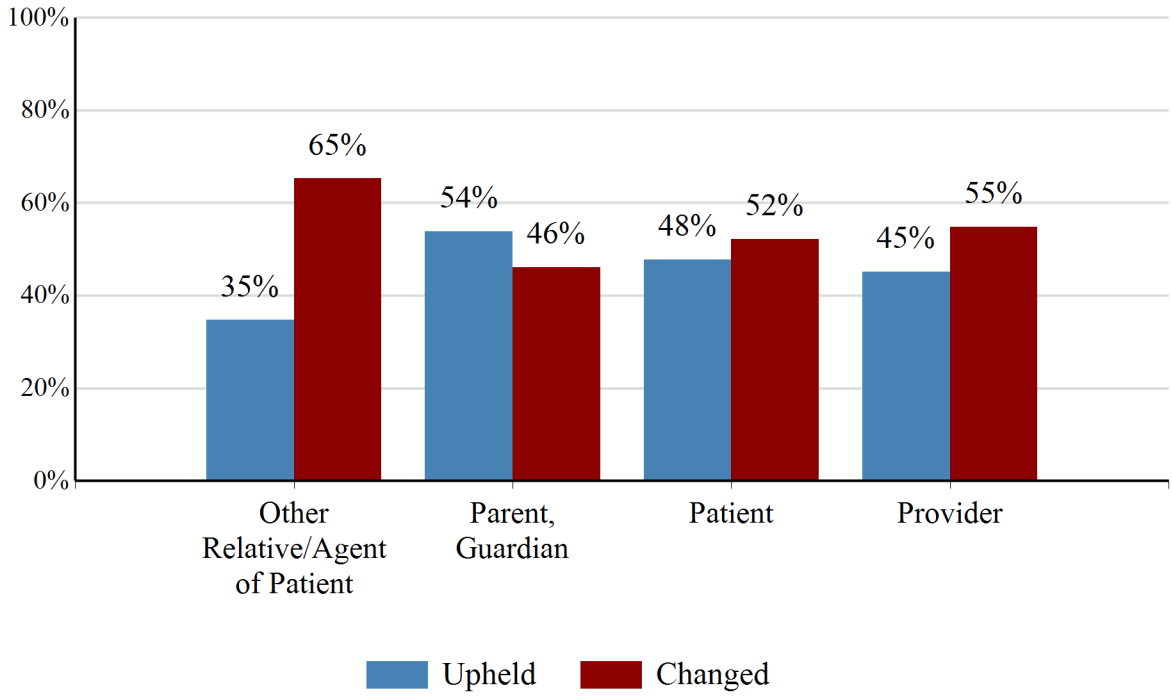
Who Filed the Case

Complaints may be filed by patients or filed on behalf of patients by providers, parents, other relatives, or other agents. The chart below shows who filed mediated Appeals and Grievances cases the HEAU closed during FY 2012.



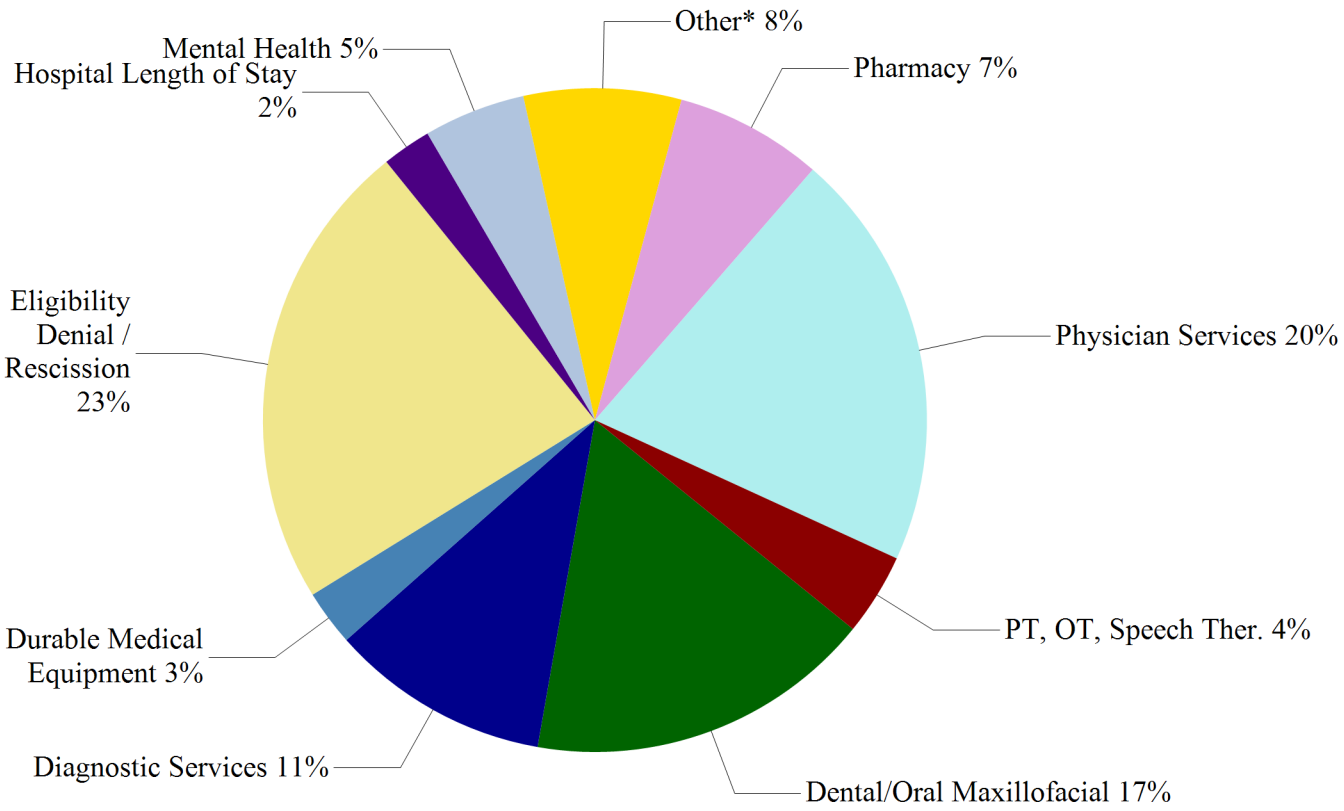
Outcomes by Who Filed the Case

The chart below reflects the outcomes, in relation to who filed the complaint, of the Appeals and Grievances cases the HEAU mediated and closed during FY 2012.



HEAU Mediated Appeals and Grievances Cases
Types of Services Denied

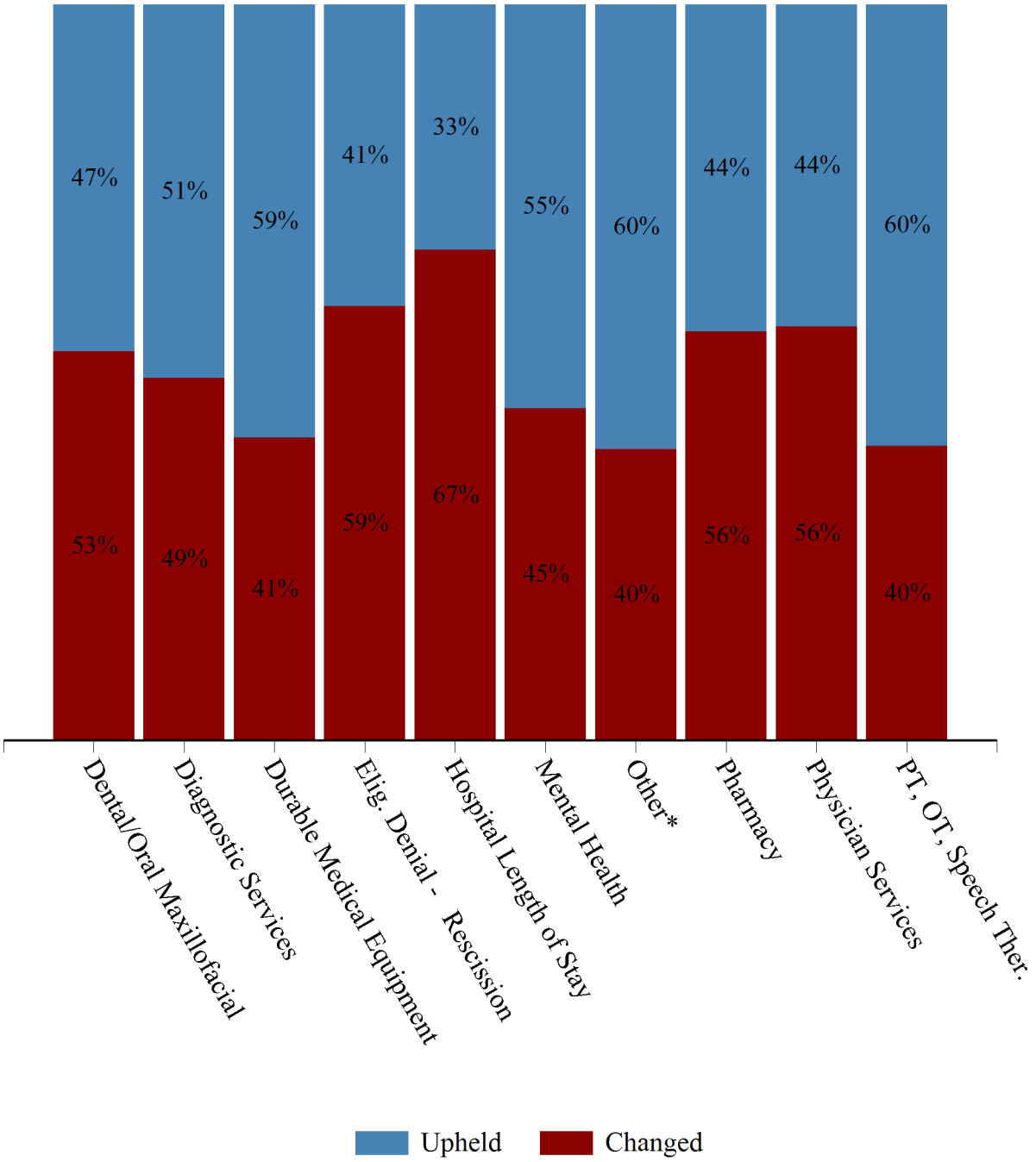
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2012.



* "Other" includes acupuncture, chiropractic, emergency room, habilitative services, home health, inpatient physical rehabilitation, optometry, podiatry, skilled nursing facility, substance abuse, transport and other non-specific categories (e.g. birthing class).

HEAU Mediated Appeals and Grievances Cases
Outcomes by Service Type

The chart below compares the outcomes of the Appeals and Grievances cases the HEAU mediated and closed during FY 2012 based on the type of services denied.



* "Other" includes acupuncture, chiropractic, emergency room, habilitative services, home health, inpatient physical rehabilitation, optometry, podiatry, skilled nursing facility, substance abuse, transport and other non-specific categories (e.g. birthing class).