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

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I. Executive Summary

The Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General (hereinafter referred to as HEAU or Unit) submits this annual report on the implementation of the Health Insurance Carrier Appeals and Grievances Law[1] (hereinafter referred to as the Appeals and Grievances Law) as required by the Maryland General Assembly.[2] HEAU is required to issue a report each November that summarizes the grievances and complaints handled by carriers, HEAU, and the Maryland Insurance Administration (MIA). HEAU is also required to evaluate the effectiveness of the internal grievance process and complaint process available to members and to propose any changes that the HEAU considers necessary to improve those processes.

As required by statute, this report will cover grievances and complaints handled during the state fiscal year 2004, beginning July 1, 2003 and concluding on June 30, 2004. The Appeals and Grievances Law is evaluated by:

- Summarizing the provisions of the law;
- Discussing implementation efforts of the health insurance carriers, MIA, and HEAU; and
- Presenting a statistical summary of grievances and complaints handled by carriers, MIA, and HEAU.

The following is an area of concern identified by an analysis of the cases filed under the Appeals and Grievances Law:

- *Patients receiving care at a participating hospital may incur significant financial liability if some of the care is provided by hospital-based physicians not participating in their health plan.*

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[1]Md. Code Ann., Insurance §15-10A-01 through §15-10A-09.

[2]Report required by Md. Code Ann., Commercial Law §13-4A-04 and Insurance § 15-10A-08.

II. Overview of the Appeals and Grievances Process

The 1998 General Assembly enacted the Appeals and Grievances Law to provide patients a process for appealing their health insurance carriers' medical necessity "adverse decisions." In 2000 the General Assembly passed HB 405, entitled "Complaint Process of Coverage Decision,"[3] which expanded the appeals and grievances process to include contractual "coverage decisions." As a result, patients in Maryland can challenge any decision by a carrier that results in the total or partial denial of a covered health care service.

As amended, the Appeals and Grievances Law established two very similar processes for patients to dispute carrier determinations, one for carrier denials based upon medical necessity and a second process for contractual denials. For both types of denials the appeals and grievances process starts when the patient receives notice from the carrier that either an adverse or coverage decision has been rendered. An adverse decision is a finding by a health insurance carrier that proposed or delivered health care services are or were not *medically necessary*, appropriate, or efficient. A coverage decision is a determination by a carrier that results in the *contractual exclusion* of a health care service.

Under the Appeals and Grievances Law, carriers must provide patients a written notice that clearly states the basis of the carrier's adverse decision, and the Health Education and Advocacy Unit (HEAU) is available to mediate the dispute with the carrier or, if necessary, help the patient to file a grievance or appeal. The notice must also inform the patient that an external review of the decision is available through the Maryland Insurance Administration (MIA) following exhaustion of the carrier's internal process as established by the Appeals and Grievances Law.

After receiving the initial denial, the patient[4] may dispute the determination through the carrier's internal grievance or appeal process. The carrier has thirty working days to review adverse decisions involving pending care and forty-five working days for care that has already been rendered. For coverage decisions the carrier has sixty working days after the date the appeal was filed with the carrier to render a decision. At the conclusion of this internal grievance or appeal process the carrier must issue a written grievance decision or a written appeal decision to the patient.

If the carrier's final decision is unfavorable to the patient, the patient may file a complaint with MIA for an external review of the carrier's determination. Only when there is a compelling reason may patients file a complaint with MIA prior to exhausting the internal grievance process.

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

[4]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 the right to file appeals and grievances on behalf of their patients.

III. Carrier Internal Grievance Process

All health insurance carriers regulated by the State of Maryland are required to establish a grievance process that complies with the provisions of the Appeals and Grievances Law. Health maintenance organizations, nonprofit health service plans, and dental plans are also covered by the requirements of the law.[5] The Appeals and Grievances Law establishes guidelines that carriers must follow in notifying patients of medical necessity and contractual denials, establishing grievance processes, and notifying members of grievance decisions.

The law also subjects carrier decisions to an external review by MIA. In cases of medical necessity denials, MIA can refer the case to medical experts at an Independent Review Organization (IRO) for evaluation and to provide MIA with an opinion as to the medical necessity of the care. MIA has the option of accepting or rejecting the opinion when making a final determination.

In addition, the Appeals and Grievances Law requires carriers to submit quarterly reports to MIA that describe the number and outcomes of internal grievances handled by the carriers. MIA then forwards the reports to HEAU for inclusion in this Report. While the quarterly report data submitted by carriers provides some basic insight into the carriers' internal grievance processes, its usefulness is limited by several factors, including:

- 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.

- The diagnosis and procedure information reported is incomplete. Carriers are required to report diagnostic or treatment codes for a limited number of complaints. While 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 HEAU. Since this information is not present, it is impossible to check the cases reported by carriers against the data recorded by MIA or the HEAU to verify the consistency of data reporting.

- Carriers are not required to report membership or enrollee numbers, so an analysis of the number of adverse decisions compared to enrollee number cannot be performed.

As of January 1, 2002 the data submitted by carriers was expanded to include the number of adverse decisions issued and to identify the type of service involved in each adverse decision. The

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[5]Health plans offered by Medicare, Medicaid, the Federal Employee Health Benefit Plan and the federally regulated self-funded plans are not subject to the appeals and grievances requirements.

HEAU's 2003 Annual Report contained the first full year of adverse decision data.

Carrier Statistics FY 2004

In addition to the highlights below, charts providing statistical detail from the data submitted by the carriers appear on pages 13-19 of this report.

1. Carriers reported 46,886 adverse decisions in FY 2004. The carriers administratively reversed 314 of these adverse decisions, or less than 1%.

2. Carriers report 5,563 internal grievances were filed in FY 2004, a less than 1% decrease from the grievances filed in FY 2003. Since 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 a total of 53% of the grievances they received. They overturned their adverse decisions in 38% of the grievances and modified their determinations in 15% of the grievances filed. This represents a 8% decrease from FY 2003, when carriers reported changing 61% of their adverse decisions.

4. Outcomes from carriers' internal grievance processes vary significantly based upon the type of service in dispute. These trends have remained fairly constant during the past four years, with adverse decisions related to pharmacy, radiology/laboratory services, and emergency room services much more likely to be reversed than adverse decisions involving mental health care and inpatient hospital services.

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 2004 carriers reported an overturned or modified rate of 17% for mental health and substance abuse; this represents the lowest reported result since starting our annual report in FY1999. This is a 2% decrease from the FY2003 Annual Report.

IV. Maryland Insurance Administration

The Maryland Insurance Administration (MIA) has regulatory oversight of insurance products offered in the State of Maryland. The General Assembly enacted the Appeals and Grievances Law in 1998 for medical necessity denials and expanded the law in 2000 to include contractual denials. It provided MIA with the financial resources needed to handle the increased caseload and to have medical experts review the carriers' medical necessity adverse decisions. In addition to granting MIA the specific authority to order external reviews, the law also describes its responsibilities and establishes deadlines for cases involving urgently needed care.

When MIA receives a written complaint from a patient or provider, it reviews it to determine if the complaint raises issues subject to the Appeals and Grievances Law. If the Appeals and Grievances Law applies, MIA must confirm that the carrier's internal grievance process has been fully exhausted. The law requires the internal process be exhausted prior to MIA examining a carrier's adverse decision unless there is a compelling reason for review prior to exhaustion. If the carrier's internal process has been exhausted or there is a compelling reason to bypass the internal grievance process, MIA will contact the carrier in writing requesting a written response to the complaint. The carrier may respond to MIA by confirming or reversing its denial or by providing additional information related to the complaint. When MIA does not have jurisdiction or the carrier's internal process has not been exhausted, MIA refers the case to HEAU for an ombudsman to assist the patient through the grievance process.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then MIA's investigator prepares the case for review. As part of the preparation, the investigator contacts the appropriate parties in writing, giving them a deadline for submitting additional documentation to be considered in the review. The parties, including the carrier, are notified simultaneously. Once MIA receives the proper documentation, the file is forwarded to an Independent Review Organization (IRO) for medical necessity review, or to an MIA reviewer for contractual denials. The IRO is asked to respond to specific questions set forth in a cover letter.

If the reviewer's recommendation is to overturn the carrier’s denial, and the Insurance Commissioner agrees, an order is issued and forwarded in writing to the carrier, along with a notice that the carrier has the right to request a hearing challenging the order. The patient or provider who filed the complaint is notified of the outcome by telephone, if possible, and then by mail.

If the reviewer's recommendation is to uphold the carrier’s denial, and the Insurance Commissioner agrees, the patient or provider is informed of the decision, by phone if possible, and that they have the right to request a hearing. The carrier is also informed of this decision by phone, and if warranted by mail.

For urgently needed care, MIA conducts an expedited external review, usually completing the above process within 24 hours. A hotline number (1-800-492-6116) is available 24 hours a day, seven days a week to respond to these emergency cases.

MIA Statistics FY 2004

In addition to the highlights listed below, charts providing statistical detail of the disposition of MIA cases appear on pages 20-24 of this report.

1. The Appeals and Grievances Unit of MIA reviewed a total of 1,248 cases that were filed between July 1, 2003 and June 30, 2004.

2. After reviewing these cases, MIA determined that 650 involved adverse decisions issued by health insurance carriers they regulated.

3. Of the 650 meeting the above criteria, MIA referred 270 to HEAU because the patient had not yet exhausted the carrier internal grievance process and there was no compelling reason to review the adverse decision prior to the exhaustion of the carrier's internal grievance process.

4. MIA initiated reviews of 380 cases in which patients challenged the grievance decision of their health insurance carrier.

5. During FY 2004, MIA issued 268 orders in cases related to carrier decisions in appeal and grievance cases.

6. Of the 268 orders issued, MIA upheld 194 or 72% of the carrier decisions, overturned 57 or 21% of the decisions, and modified 17 or 6% of the decisions.

V. The Health Education and Advocacy Unit

The Health Education and Advocacy Unit (HEAU) was established by an act of the 1986 General Assembly. 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, and to assist patients with health equipment warranty issues. To fulfill these responsibilities, HEAU built upon the established mediation program within the Consumer Protection Division of the Attorney General's Office. Based upon HEAU's successful mediation efforts, the General Assembly selected the Unit to be the first line consumer assistance agency when they passed the Appeals and Grievances Law in 1998.

The Appeals and Grievances Law requires that health insurance carriers notify patients that HEAU is available to assist them in appealing an adverse decision. With each adverse decision issued, carriers must provide patients with HEAU's contact information including HEAU's toll-free hotline (1-877-261-8807). In addition, HEAU conducts outreach programs to increase patient and provider awareness of the rights and resources granted under the Appeals and Grievances Law.

When HEAU receives a request for assistance, the Unit gathers basic information from the health insurance carriers related to the services or care denied. Specifically, 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. Once the carrier responds, HEAU gathers information about the patient's condition from the patient and provider. The object is to assemble all relevant information or documents necessary for the carrier to determine if the patient meets the criteria established by the health plan, or that the contractual denial is incorrect. HEAU then presents this information to the carrier for reconsideration of the denial. Many complaints are resolved during this information exchange process. If not resolved, HEAU will prepare and file a formal written grievance with the health insurance carrier on behalf of the patient.

If, at the conclusion of the grievance process, the carrier continues to deny the care, the patient or provider may request that HEAU transfer the case to MIA for external review. HEAU refers the case to MIA with a copy of all relevant medical and insurance documentation.

HEAU Statistics FY 2004

In addition to the highlights listed below, charts providing statistical detail of the disposition of HEAU cases appear on pages 25-35 of this report.

1. HEAU closed 2,061 cases during FY 2004.

2. The appeals and grievances cases fall into two categories: denials based upon medical necessity and denials based upon contractual exclusions. HEAU- mediated cases were 64% contractual denials and 36% medical necessity denials.

3. HEAU mediation resulted in 46% of the contractual denial cases being overturned or modified by the carrier; 72% of the medical necessity denial cases were overturned or modified.

4. HEAU assisted patients in obtaining more than $1.2 million in claims payments in mediated appeal and grievance cases in FY 2004, bringing the total to more than $6.95 million in claims payments related to the appeal and grievance cases since the law became effective in January 1999.

5. HEAU mediation efforts resulted in adverse decisions being changed in 66% of cases involving carriers subject to MIA regulations.

6. In cases filed against health plans not subject to review by MIA, HEAU mediation efforts resulted in carriers changing their decisions 36% of the time.

VI. Areas of Concern

Based upon the HEAU's experiences in implementing the appeals and grievances process, we have identified the following area of concern.

Patients receiving care at a participating hospital may incur significant financial liability if some of the care is provided by hospital-based physicians not participating in their health plan.

Each year HEAU receives complaints from patients who have incurred significant financial responsibility after receiving care at a participating hospital from a hospital-based physician who does not participate with their managed care health plan. Examples of hospital-based doctors include emergency room doctors, pathologists, neonatologists, radiologists, surgical assistance, and anesthesiologists.

This occurs even when the PPO or POS managed care plan pays for the covered services rendered by the nonparticipating provider at the same level they pay participating providers, because in a PPO/POS, the provider can bill the patient if the total amount is not paid by the plan. The HMO member in most instances is protected by State mandated prohibition against balance billing for covered services. In short, the PPO/POS patient is responsible for the difference between what the nonpreferred provider charged and what the plan paid. Below is an excerpt from a letter written by a consumer describing the impact of this system.

> "July 5, 2003 I was rushed to the emergency room at Fort Washington Medical Center for severe abdominal pain. This medical center is a participating provider with my plan. In going to a participating provider I assumed the attending physician would also be covered under my plan. I was surprised to find that the physician was not covered and I have received a bill for $309.00 from the physician's billing department."
>
> "As [Carrier] has a contract with the participating hospital I believe the hospital must be required by [Carrier] to have their ER physicians participating in the plans that the hospital accepts. I was given no choice over my physician, but the hospital has the choice to hire or contract only those who accept the plans they participate with. As a client of [Carrier] I expect them to protect me by not only having hospitals and ER's that participate in their plan, but the Dr's in the ER to also participate and/or be covered by the same plan."

In this case the patient still owed $207.19 after the carrier paid the amount it pays to participating providers. Under current law, the patient was required to pay the remaining portion of the bill and the provider insisted it be paid. During the mediation process the carrier informed HEAU that it has no participating physicians in the Fort Washington emergency room. Therefore,

the emergency room doctors can bill all Plan members that utilize the emergency room at the Fort Washington Medical Center, despite the fact that the Center is a participating provider in the Plan.

In addition to services provided in emergency rooms, HEAU has also received complaints about nonparticipating hospital-based providers in other situations, including non-emergency surgeries and deliveries of babies. In those instances, patients chose a local hospital and doctor in their plan to have a surgery performed or a baby delivered. After the care was rendered, patients found out that some hospital-based pathologists, neonatologists, or anesthesiologists did not participate and the patient was held responsible for paying the difference between what the nonparticipating provider charged and what the plan paid. One consumer wrote the following about her experience with this practice.

> "I am writing to appeal the recent payment made to the Howard County Neonatal providers. According to your explanation of benefits, it appears that I am being penalized for using services of a "non-participating" provider. I had no other option available when choosing these providers. They are the only neonatal providers available at Howard County General Hospital. I followed my plan rules and went to a participating hospital. These providers are contracted for their services but are not reimbursed by the hospital for them. This is out of my control."

> "The services in question are for Neonatal care during the birth of my son. It seems unreasonable that emergency situations would not be covered differently than a "planned"admission, particularly for newborns. At the time of delivery, the luxury of time to search for a "participating provider" was not available without compromising the health of our son."

As both these consumers point out, unless hospital-based physicians are required to participate in the health plans accepted by the hospital, there is no way that patients can avoid these unexpected and uncovered medical expenses.

VII. Conclusion

Maryland's Appeals and Grievances Law continues to provide significant assistance to patients challenging health insurance adverse decisions. In past years enhancements to the 1999 Appeals and Grievance Law improved patient access to HEAU and MIA assistance by requiring better notices to patients, lengthening patient deadlines, and broadening the scope of the types of denials covered.

Still, we must be aware of possible barriers to the appeal and grievance processes. Consumers need the ability to predetermine their financial liability when they seek care from a hospital participating in their health plan. Care from a nonparticipating hospital-based physician can severely impact consumers' financial liability and they need the ability to assess this prior to care being rendered.

VIII. Appendix

Carrier Data

Reported by Carriers

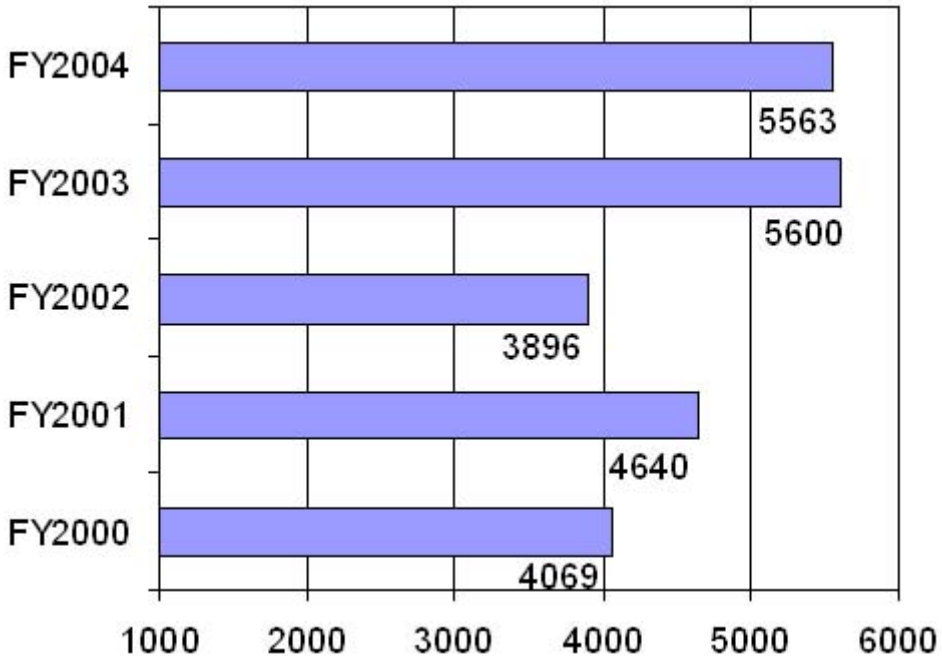
Fiscal Year 2004

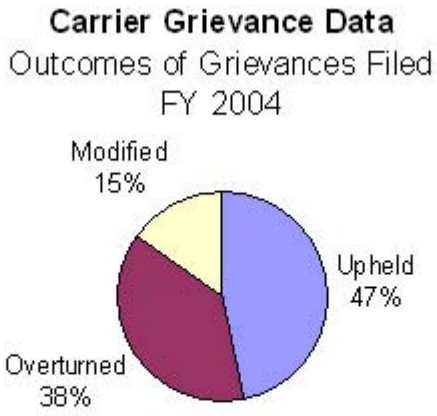
	Adverse Decisions		Grievances Filed		
Carrier	Total	Admin. Reversal	Total	Upheld	Overturned/ Modified
Aetna Dental Inc.	3	7	49	69%	31%
Aetna Life Insurance Company	198	9	1	100%	0%
Aetna U.S. Healthcare - Largo, MD	4752	207	302	35%	65%
American Republic Insurance Company	1	0	0	0%	0%
Ameritas Life Insurance Corporation	4	1	1	100%	0%
CareFirst BlueChoice, Inc.	7012	0	853	44%	56%
CareFirst of Maryland Inc.	9324	15	940	53%	47%
Celtic Insurance Company	0	0	7	14%	86%
CIGNA Dental Health of Maryland, Inc.	927	0	13	15%	85%
CIGNA Healthcare Mid-Atlantic, Inc.	289	2	70	59%	41%
Companion Life Insurance Company	27	1	6	33%	67%
Connecticut General Life Insurance Co.	555	1	143	50%	50%
Continental Assurance Company	30	2	32	78%	22%
Coventry Health Care of Delaware	260	0	36	67%	33%
Dental Benefit Providers of MD, Inc.	1628	0	93	23%	77%
Fidelity Insurance Company	256	0	250	56%	44%
Fortis Benefits Insurance Company	23	13	33	30%	70%
Fortis Health	14	0	7	43%	57%
Freestate Health Plan, Inc.	44	1	0	0%	0%
Golden Rule Insurance Company	4	1	4	75%	25%
Great West Life & Annuity Insurance Co.	1	0	0	0%	0%
Group Dental Service of Maryland, Inc.	8349	2	602	9%	91%

	Adverse Decisions		Grievances Filed		
Carrier	Total	Admin. Reversal	Total	Upheld	Overturned/ Modified
Group Hospitalization & Medical Services, Inc. T/A Carefirst Blue Cross	2370	1	229	51%	49%
Guardian Life Insurance Co. of America	808	15	197	35%	65%
Humana Dental Insurance Company	3	0	7	43%	57%
Humana Insurance Company	0	0	3	0%	100%
Jefferson Pilot Financial Insurance Co.	12	0	4	100%	0%
Kaiser Permanente	476	11	111	28%	72%
MAMSI Life and Health Insurance Co.	2376	0	383	61%	39%
MD-Individual Practice Association, Inc.	906	0	169	57%	43%
Nationwide Life Insurance Company	2	0	0	0%	0%
New York Life Insurance	1	0	1	0%	100%
Optimum Choice, Inc.	5336	0	863	62%	38%
Preferred Health Network - HMO, Inc.	238	0	48	40%	60%
Reliance Standard Life	1	0	1	100%	0%
Reliastar Life Insurance Company	0	0	2	0%	100%
Standard Insurance Company	3	0	3	100%	0%
The Mega Life and Health Insurance Co.	0	0	11	27%	73%
The Prudential Insurance Co. of America	1	0	1	100%	0%
Trustmark Insurance Company	5	2	4	75%	25%
UNICARE Life and Health Insurance Co.	66	0	14	79%	21%
Unimerica Insurance Company	26	0	0	0%	0%
Union Labor Life Insurance Company	13	1	9	44%	56%
United HealthCare Insurance Company	234	0	35	60%	40%
United Healthcare of the Mid-Atlantic	257	0	24	88%	13%
United of Omaha Life Insurance Co.	7	0	7	29%	71%
United Wisconsin Life Insurance Co.	44	22	0	0%	0%
Total	**46886**	**314**	**5563**	**47%**	**53%**

Carrier Data
Grievances Filed
Five Year Comparison

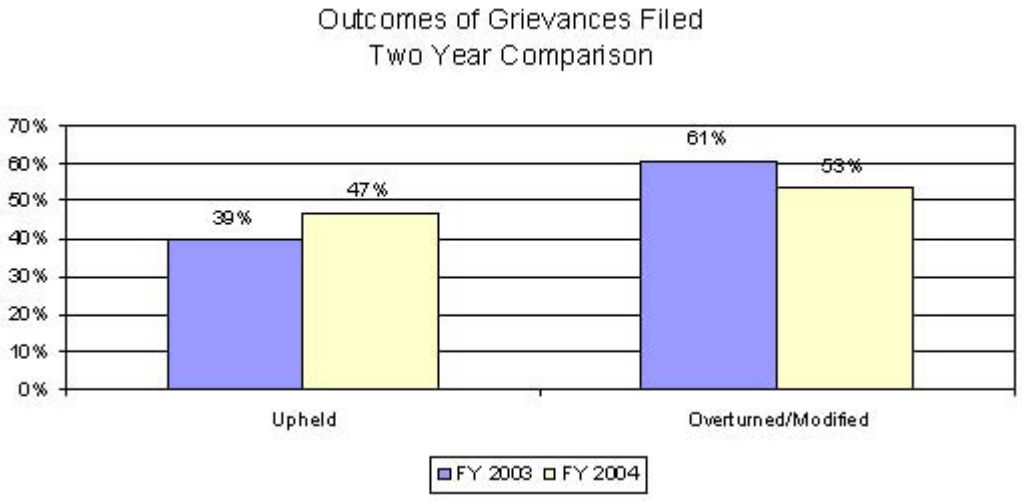
This chart shows the history of carrier grievances under the A&G Law since the first full year of data.



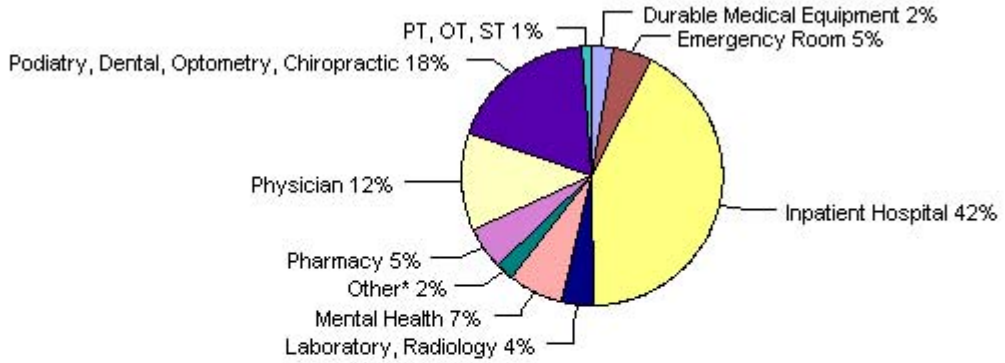


This chart describes the outcomes of the 5563 internal grievances reported by carriers during FY 2004.

This chart compares the year to year outcomes of grievances filed with carriers.

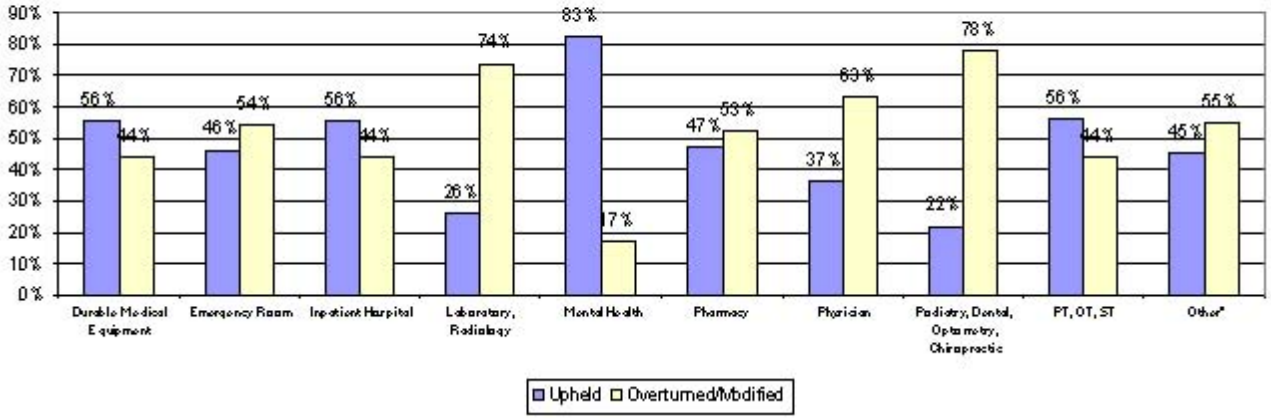


Carrier Grievance Data
Type of Service Involved in Grievances Filed
FY 2004



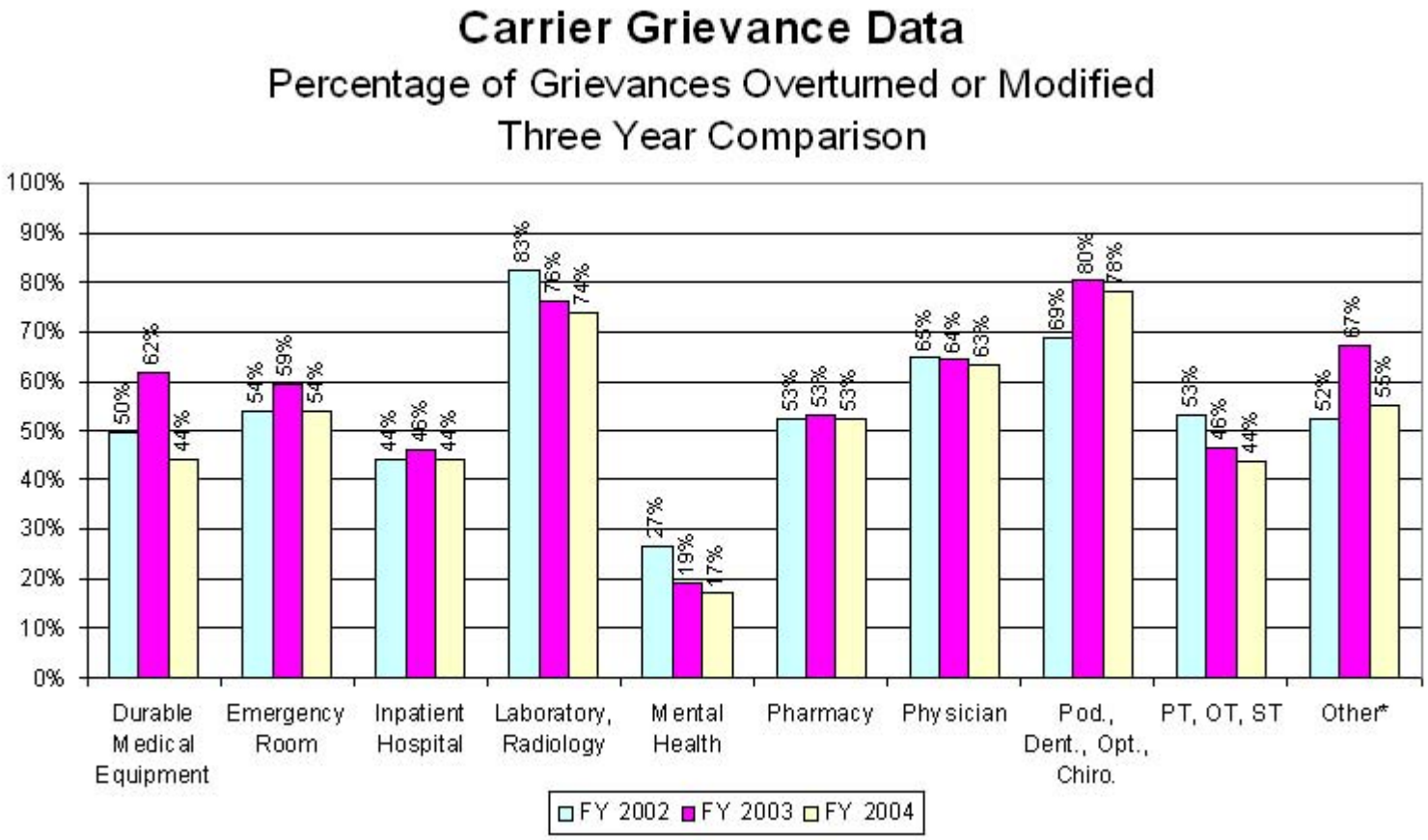
Carriers are required to report the type of service involved in the internal grievances they receive. The above chart details the types of services involved in internal grievances as reported by carriers in FY 2004.

Outcomes of Grievances by Type of Service
FY2004



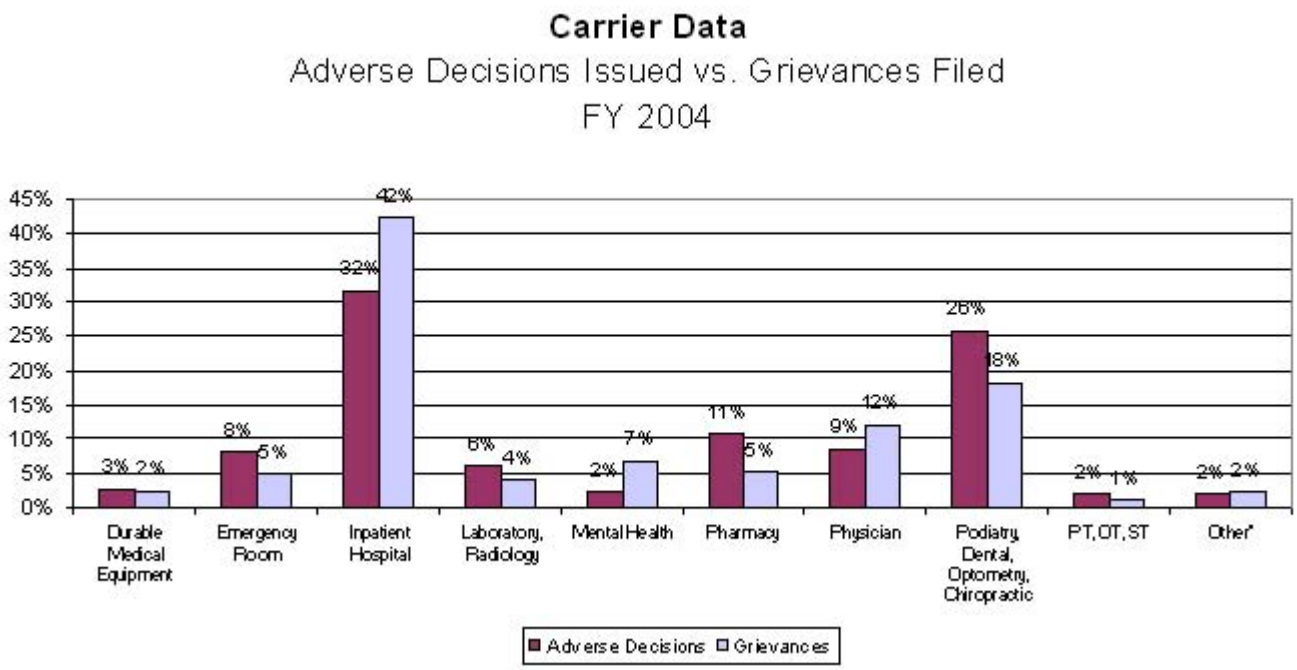
Carriers are required to identify the type of service involved in the internal grievances they receive as well as the outcomes of those grievances. This chart compares the variance in the outcome of grievances based upon the type of service being disputed in the grievance. This chart is based upon carrier reported data. The cases reported as overturned or modified have been combined to more clearly present the data. The carriers report Mental Health and Substance Abuse together.

* In both of the above charts, Other includes: Skilled Nursing Facility, Sub Acute Facility, Nursing Home, Home Health and Other cases where the Type of Service did not fit an existing category.



This chart compares the percentage of cases reported as overturned or modified, comparing FY 2002, FY 2003, and FY 2004 outcomes as reported by the carriers.

* Other includes: Skilled Nursing Facility, Sub Acute Facility, Nursing Home, Home Health and Other cases where the Type of Service did not fit an existing category.



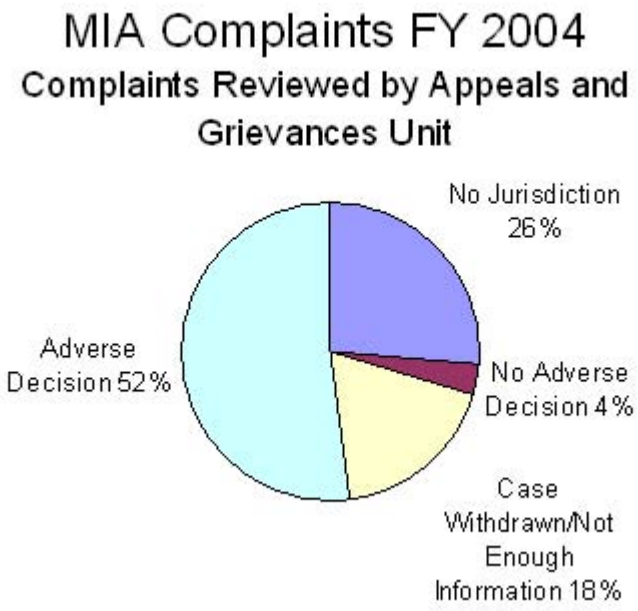
* Other includes: Skilled Nursing Facility, Sub Acute Facility, Nursing Home, Home Health and Other cases where the Type of Service did not fit an existing category.

MIA Appeals and Grievances Complaints

Complaints Listed by Carrier

FY 2004

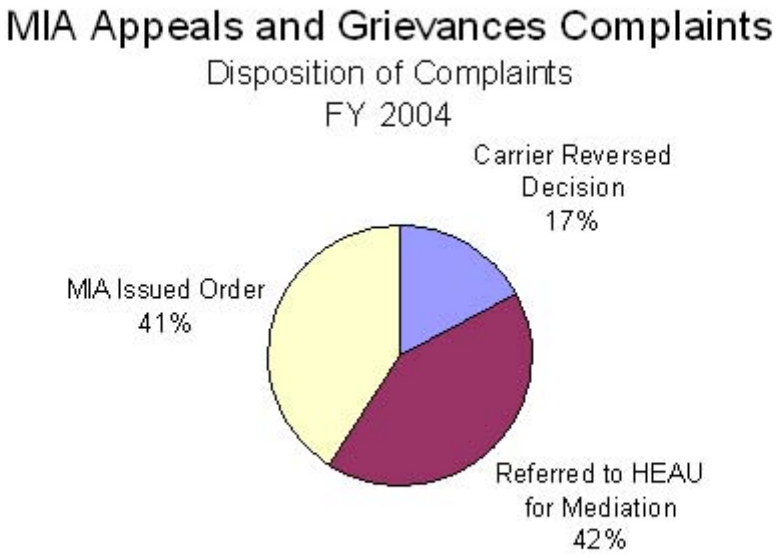
Carrier	Total	Carrier Upheld by MIA		Carrier Overturned by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
Aetna USHealthcare	14	7	50%	2	14%	0	0%	5	36%
American Republic	1	1	100%	0	0%	0	0%	0	0%
BlueChoice, Inc.	52	27	52%	3	6%	3	6%	19	37%
CareFirst of Maryland, Inc.	107	60	56%	20	19%	5	5%	22	21%
CIGNA Dental Health of Maryland	2	2	100%	0	0%	0	0%	0	0%
CIGNA HealthCare Mid-Atlantic	6	3	50%	0	0%	0	0%	3	50%
Connecticut General Life Insr. Co.	3	1	33%	0	0%	0	0%	2	67%
Coventry Health Care of Delaware	12	5	42%	3	25%	2	17%	2	17%
Dental Benefit Providers of MD	5	0	0%	0	0%	0	0%	5	100%
Fidelity Insurance Company	14	7	50%	2	14%	0	0%	5	36%
Fortis Health	3	2	67%	0	0%	0	0%	1	33%
Group Hospitalization & Medical Serv.	6	4	67%	2	33%	0	0%	0	0%
Guardian Life Insurance Co.	1	0	0%	0	0%	0	0%	1	100%
Kaiser Permanente	22	11	50%	1	5%	2	9%	8	36%
Maryland Health Insurance Plan	18	5	28%	0	0%	1	6%	12	67%
MAMSI Life & Health Insurance Co.	45	24	53%	11	24%	3	7%	7	16%
MDIPA	6	3	50%	1	17%	0	0%	2	33%
Metropolitan Life Ins. Co.	1	0	0%	0	0%	0	0%	1	100%
Optimum Choice	51	26	51%	11	22%	1	2%	13	25%
PHN-HMO	3	2	67%	0	0%	0	0%	1	33%
Unicare Life & Health	1	1	100%	0	0%	0	0%	0	0%
United Concordia	1	0	0%	0	0%	0	0%	1	100%
United HealthCare of Mid-Atlantic	1	1	100%	0	0%	0	0%	0	0%
United HealthCare Insurance Co.	4	1	25%	1	25%	0	0%	2	50%
TOTAL	**379**	**193**	**51%**	**57**	**15%**	**17**	**4%**	**112**	**30%**



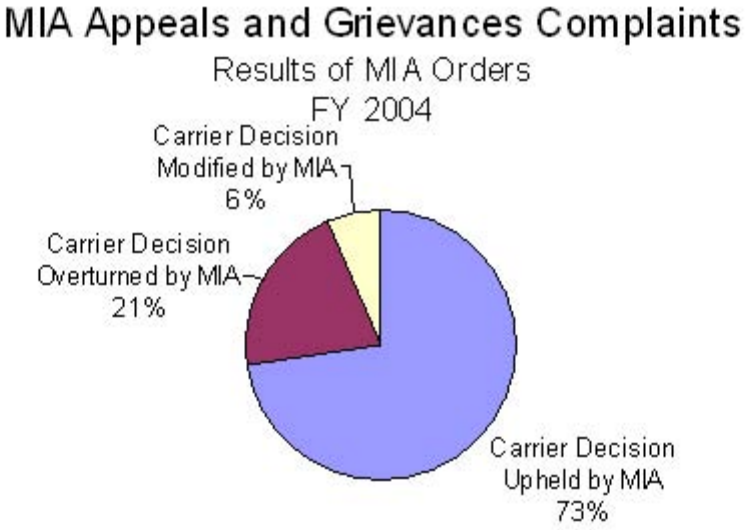
When the MIA Appeals and Grievances Unit receives a written complaint, it reviews it to determine:

- Is the carrier subject to state jurisdiction?
- Does the complaint include a dispute of an adverse decision?

Some cases are withdrawn or there is not enough information to complete the review. This chart details the outcomes of MIA's review of cases during FY 2004.



During FY 2004, MIA determined that 650 complaints challenged adverse decisions made by carriers that were subject to state jurisdiction. Cases in which the patient had not exhausted the carrier's internal grievance process were referred to HEAU. The remaining cases were either resolved by carriers during the review process or resulted in an MIA order.



MIA issued 268 orders related to Appeals and Grievances Complaints during FY 2004. This chart describes the outcomes of those orders.

MIA Appeals and Grievances Complaints
Type of Service Involved in and Outcomes of Complaints
FY 2004

Type of Procedure	Total		Carrier Upheld by MIA		Carrier Overturned by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
Acupuncture	6	2%	6	100%	0	0%	0	0%	0	0%
Ancillary Services	5	1%	5	100%	0	0%	0	0%	0	0%
Cosmetic	12	3%	10	83%	1	8%	0	0%	1	8%
Clinical Trial	3	1%	1	33%	1	33%	0	0%	1	33%
Claim Denial	8	2%	3	38%	0	0%	0	0%	5	63%
Denial of Hospital Days	56	15%	24	43%	19	34%	3	5%	10	18%
Durable Medical Equipment	15	4%	9	60%	0	0%	2	13%	4	27%
Dental Care Services	23	6%	11	48%	1	4%	0	0%	11	48%
Denial of Care	3	1%	0	0%	0	0%	0	0%	3	100%
Denial of Out-Patient Services	1	0%	1	100%	0	0%	0	0%	0	0%
Experimental	13	3%	7	54%	4	31%	0	0%	2	15%
Emergency Room Denial	12	3%	4	33%	3	25%	0	0%	5	42%
Eye Care Services	2	1%	1	50%	0	0%	0	0%	1	50%
Home Care Services	1	0%	1	100%	0	0%	0	0%	0	0%
Inpatient Rehabilitation Services	6	2%	1	17%	2	33%	1	17%	2	33%
Inpatient Hospital Denial	1	0%	0	0%	1	100%	0	0%	0	0%
Lab, Imaging, Testing Services	11	3%	4	36%	1	9%	0	0%	6	55%
Medical Food	3	1%	2	67%	0	0%	0	0%	1	33%
Mental Health Substance Abuse-Inpt	50	13%	24	48%	10	20%	9	18%	7	14%
Mental Health Partial Hospitalization	9	2%	7	78%	1	11%	1	11%	0	0%
Mental Health Substance Abuse-Out	8	2%	3	38%	2	25%	0	0%	3	38%
Morbid Obesity	2	1%	1	50%	0	0%	0	0%	1	50%
Nursing Home Services	1	0%	1	100%	0	0%	0	0%	0	0%
Physician Services	77	20%	49	64%	6	8%	0	0%	22	29%
Pharmacy Services	25	7%	5	20%	2	8%	0	0%	18	72%
PT,ST, OT	17	4%	7	41%	1	6%	1	6%	8	47%
Podiatry Services	1	0%	0	0%	0	0%	0	0%	1	100%
Skilled Nursing Facility Care Services	5	1%	3	60%	2	40%	0	0%	0	0%
Transportation Services	4	1%	4	100%	0	0%	0	0%	0	0%
TOTAL	**380**	**100%**	**194**	**51%**	**57**	**15%**	**17**	**4%**	**112**	**29%**

The above chart identifies the types of services involved in Appeals and Grievances Complaints handled by MIA during FY 2004. It shows how the outcome varies based upon the types of services involved in the complaints.

HEAU Appeals and Grievances Cases

Cases Listed by Carrier

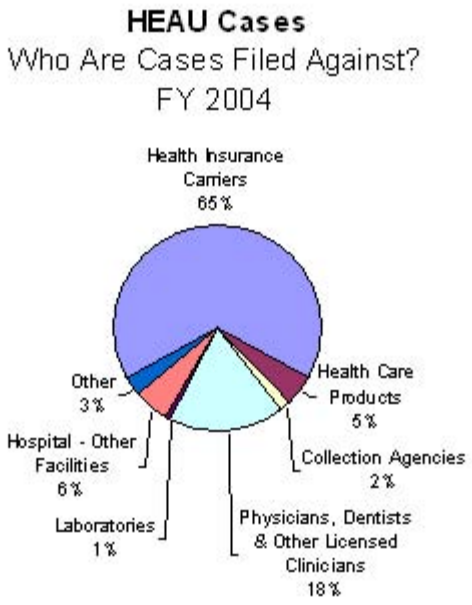
FY 2004

HEAU Appeals & Grievances Cases by Carrier		Total	Upheld		Overturned/Modified	
Aetna US Healthcare	Not State Regulated	18	13	72%	5	28%
	State Regulated	23	4	17%	19	83%
	Total HEAU Complaints	**41**	**17**	**41%**	**24**	**59%**
AFTRA Health and Retirement Funds	Not State Regulated	2	2	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**2**	**100%**	**0**	**0%**
American Republic Insurance Company	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Anthem Blue Cross Blue Shield	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield Federal Employee Program	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield Of Maryland	Not State Regulated	3	0	0%	3	100%
	State Regulated	1	1	100%	0	0%
	Total HEAU Complaints	**4**	**1**	**25%**	**3**	**75%**
Blue Cross Blue Shield Of Pennsylvania	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
CareFirst	Not State Regulated	48	33	69%	15	31%
	State Regulated	106	45	42%	61	58%
	Total HEAU Complaints	**154**	**78**	**51%**	**76**	**49%**
Carefirst Blue Choice	Not State Regulated	4	2	50%	2	50%
	State Regulated	9	4	44%	5	56%
	Total HEAU Complaints	**13**	**6**	**46%**	**7**	**54%**
CIGNA	Not State Regulated	14	8	57%	6	43%
	State Regulated	17	3	18%	14	82%
	Total HEAU Complaints	**31**	**11**	**35%**	**20**	**65%**
CIGNA Dental	Not State Regulated	0	0	0%	0	0%
	State Regulated	2	0	0%	2	100%
	Total HEAU Complaints	**2**	**0**	**0%**	**2**	**100%**
CoreSource, A Trustmark Co.	Not State Regulated	0	0	0%	0	0%
	State Regulated	2	0	0%	2	100%
	Total HEAU Complaints	**2**	**0**	**0%**	**2**	**100%**

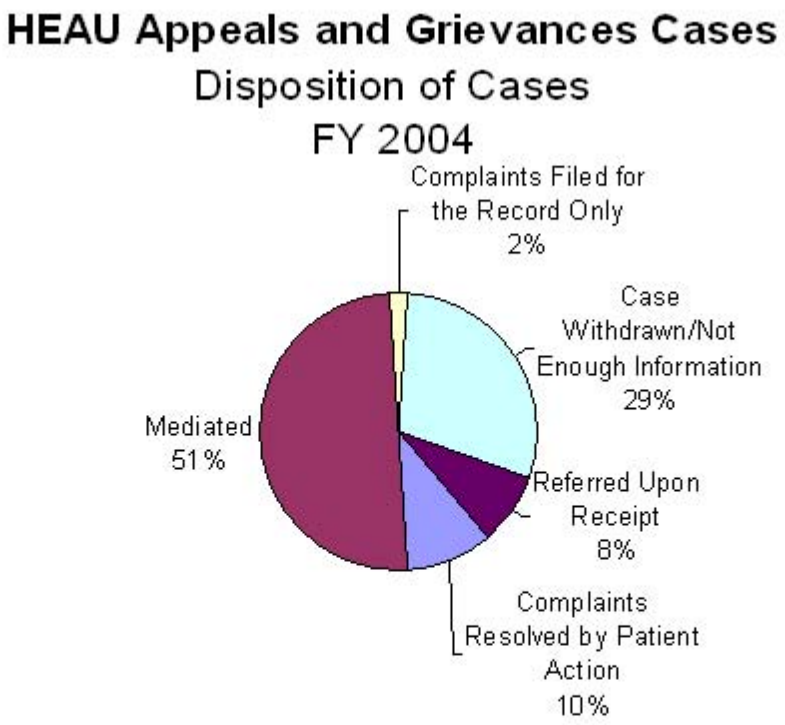
HEAU Appeals & Grievances Cases by Carrier		Total	Upheld		Overturned/Modified	
Coventry Health Care	Not State Regulated	2	2	100%	0	0%
	State Regulated	8	3	38%	5	63%
	Total HEAU Complaints	**10**	**5**	**50%**	**5**	**50%**
Delta Dental of Pennsylvania	Not State Regulated	1	1	100%	0	0%
	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**2**	**1**	**50%**	**1**	**50%**
Dental Benefit Providers, Inc.	Not State Regulated	0	0	0%	0	0%
	State Regulated	2	0	0%	2	100%
	Total HEAU Complaints	**2**	**0**	**0%**	**2**	**100%**
FELRA & UFCW Health and Welfare Fund	Not State Regulated	2	2	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**2**	**100%**	**0**	**0%**
Fidelity Insurance	Not State Regulated	6	3	50%	3	50%
	State Regulated	19	6	32%	13	68%
	Total HEAU Complaints	**25**	**9**	**36%**	**16**	**64%**
Fortis Benefits	Not State Regulated	1	1	100%	0	0%
	State Regulated	2	1	50%	1	50%
	Total HEAU Complaints	**3**	**2**	**67%**	**1**	**33%**
Freestate Health Plan	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Golden Rule Insurance	Not State Regulated	2	1	50%	1	50%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**1**	**50%**	**1**	**50%**
Group Benefit Services (GBS)	Not State Regulated	2	1	50%	1	50%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**2**	**1**	**50%**	**1**	**50%**
Guardian Life Insurance Co	Not State Regulated	1	1	0%	0	0%
	State Regulated	1	1	100%	0	0%
	Total HEAU Complaints	**2**	**2**	**100%**	**0**	**0%**
Guardian Life Insurance Company of America	Not State Regulated	1	0	0%	1	100%
	State Regulated	8	0	0%	8	100%
	Total HEAU Complaints	**9**	**0**	**0%**	**9**	**100%**
Highmark Blue Cross Blue Shield	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
Humana Insurance Company	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**

HEAU Appeals & Grievances Cases by Carrier		Total	Upheld		Overturned/Modified	
Johns Hopkins Employer Health Programs	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Kaiser Permanente	Not State Regulated	5	2	40%	3	60%
	State Regulated	22	3	14%	19	86%
	Total HEAU Complaints	**27**	**5**	**19%**	**22**	**81%**
Mail Handlers Benefit Plan	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
MAMSI Life & Health Insurance Company	Not State Regulated	4	3	75%	1	25%
	State Regulated	28	16	57%	12	43%
	Total HEAU Complaints	**32**	**19**	**59%**	**13**	**41%**
Maryland Health Insurance Plan	Not State Regulated	2	2	100%	0	0%
	State Regulated	8	0	0%	8	100%
	Total HEAU Complaints	**10**	**2**	**20%**	**8**	**80%**
Maryland Physicians Care MCO	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
MDIPA	Not State Regulated	4	2	50%	2	50%
	State Regulated	7	3	43%	4	57%
	Total HEAU Complaints	**11**	**5**	**45%**	**6**	**55%**
Medicare	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Medicare Part B Trailblazers	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
MEGA Life and Health Insurance Company	Not State Regulated	1	1	100%	0	0%
	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**2**	**1**	**50%**	**1**	**50%**
Metlife	Not State Regulated	1	0	0%	1	100%
	State Regulated	1	1	100%	0	0%
	Total HEAU Complaints	**2**	**1**	**50%**	**1**	**50%**
NCAS	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
One Health Plan	Not State Regulated	3	0	0%	3	100%
	State Regulated	4	1	25%	3	75%
	Total HEAU Complaints	**7**	**1**	**14%**	**6**	**86%**

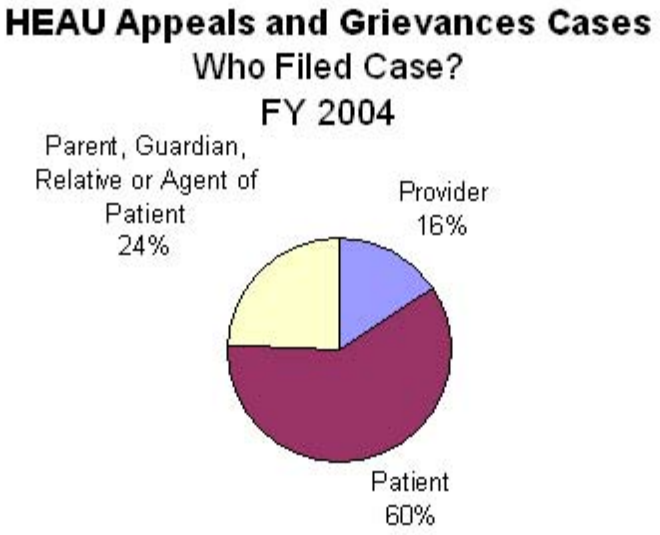
HEAU Appeals & Grievances Cases by Carrier		Total	Upheld		Overturned/Modified	
Optimum Choice	Not State Regulated	7	5	71%	2	29%
	State Regulated	30	16	53%	14	47%
	Total HEAU Complaints	**37**	**21**	**57%**	**16**	**43%**
Oxford Health Plans	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Preferred Health Network - PHN	Not State Regulated	0	0	0%	0	0%
	State Regulated	3	2	67%	1	33%
	Total HEAU Complaints	**3**	**2**	**67%**	**1**	**33%**
Principal Financial Group	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
The Dental Network	Not State Regulated	0	0	0%	0	0%
	State Regulated	1	1	100%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Trustmark	Not State Regulated	1	0	0%	1	100%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
Ultra Benefits, Inc.	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
UNICARE	Not State Regulated	0	0	0%	0	0%
	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
United American Insurance Company	Not State Regulated	0	0	0%	0	0%
	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
United Concordia Companies, Inc.	Not State Regulated	5	4	80%	1	20%
	State Regulated	9	5	56%	4	44%
	Total HEAU Complaints	**14**	**9**	**64%**	**5**	**36%**
United Healthcare	Not State Regulated	14	10	71%	4	29%
	State Regulated	27	3	11%	24	89%
	Total HEAU Complaints	**41**	**13**	**32%**	**28**	**68%**
Unknown Business	Not State Regulated	0	0	0%	0	0%
	State Regulated	1	0	0%	1	100%
	Total HEAU Complaints	**1**	**0**	**0%**	**1**	**100%**
UnumProvident Corporation	Not State Regulated	1	1	100%	0	0%
	State Regulated	0	0	0%	0	0%
	Total HEAU Complaints	**1**	**1**	**100%**	**0**	**0%**
Total	**Not State Regulated**	**171**	**110**	**64%**	**61**	**36%**
	State Regulated	**345**	**119**	**34%**	**226**	**66%**
	Total HEAU Complaints	**516**	**229**	**44%**	**287**	**56%**



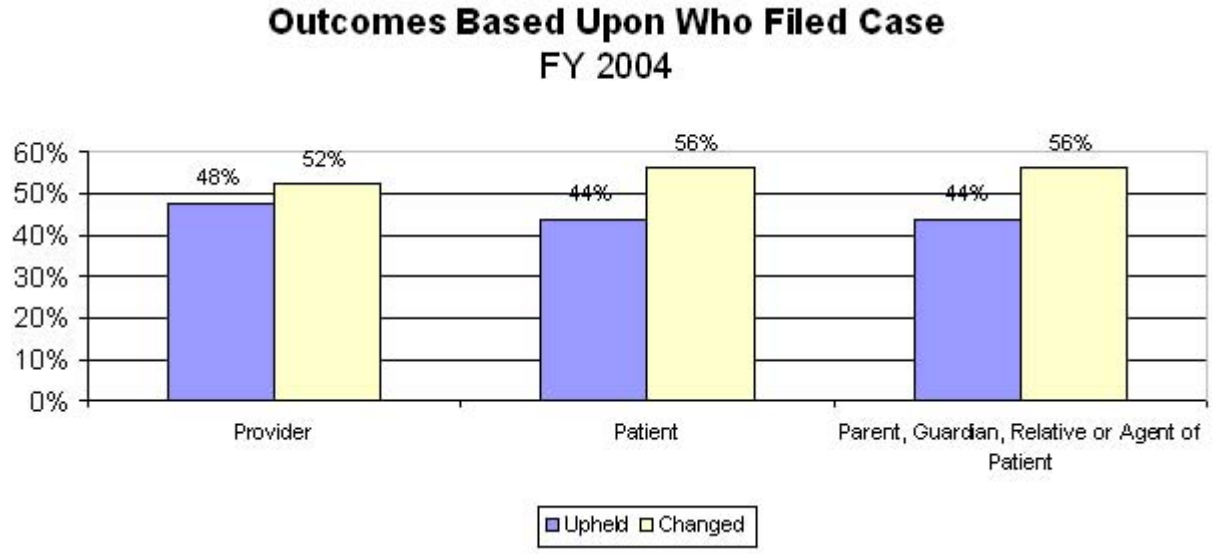
The HEAU mediates several types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve helping patients obtain copies of their medical records, mediating disputes related to sales and service problems with health care products and assisting patients with various other problems encountered in the healthcare marketplace. This chart shows the types of industries against which complaints were filed with HEAU during FY 2004.



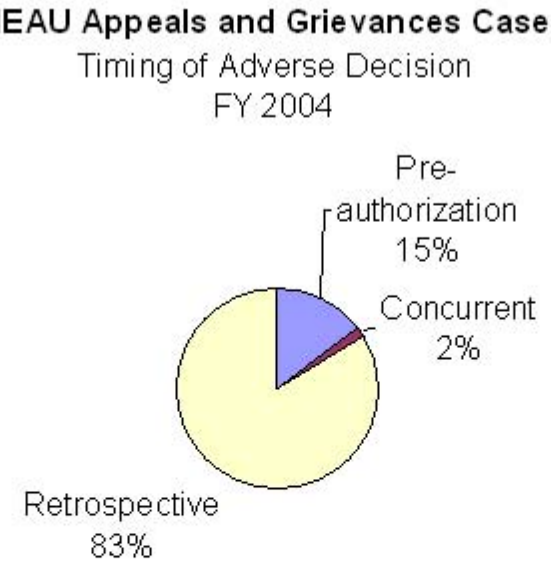
The HEAU closed 1026 cases related to patients who disputed carrier adverse decisions. However, not all of these cases were mediated by HEAU. While the majority of these cases are mediated, some are filed for the record only and others are resolved by patients without direct HEAU assistance. This chart shows the disposition of all Appeals and Grievances cases closed by HEAU during FY 2004.



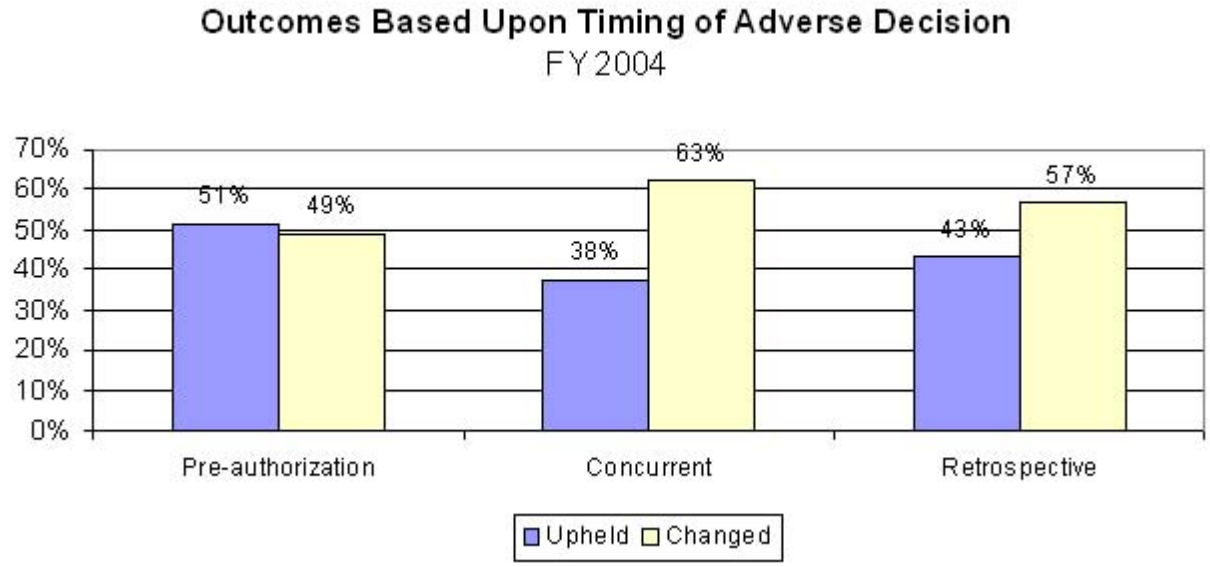
Cases may be filed on behalf of patients by providers, parents, relatives or other agents of patients. The above chart indicates who filed cases with HEAU.



This chart shows the outcome of Appeals and Grievances Cases mediated by HEAU during FY 2004. Cases resulting in carriers overturning or modifying adverse decisions have been combined for this chart.

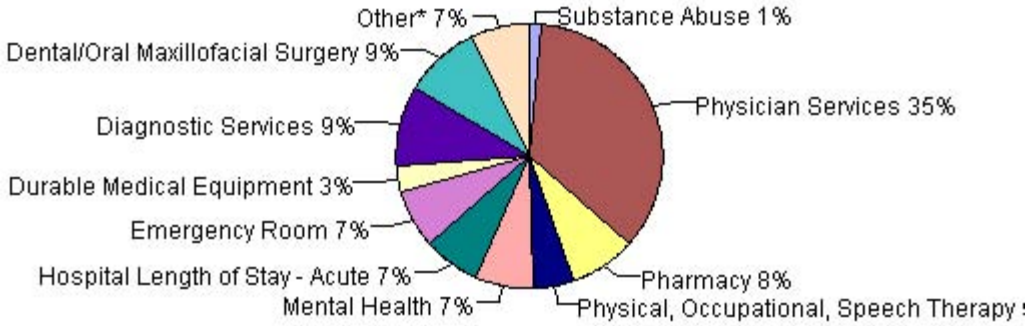


Carriers may issue adverse decisions before (pre-authorization), during (concurrent) or after (retrospective) treatment. This chart indicates when the adverse decisions were issued in Appeals and Grievances Cases mediated by HEAU during FY 2004.



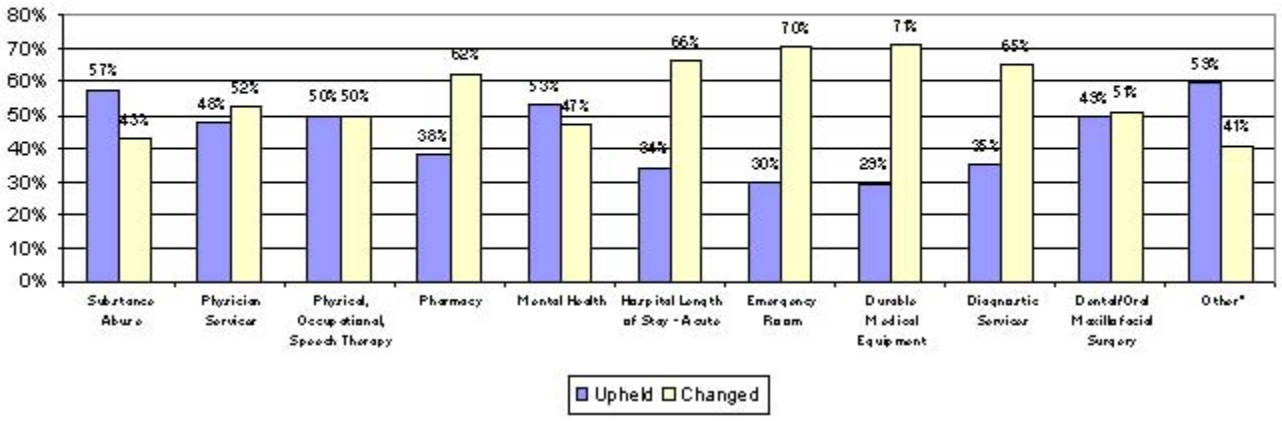
This chart shows the outcomes of Appeals and Grievances Cases mediated by HEAU during FY 2004.

HEAU Appeals and Grievances Cases
Type of Service Involved in Cases
FY 2004



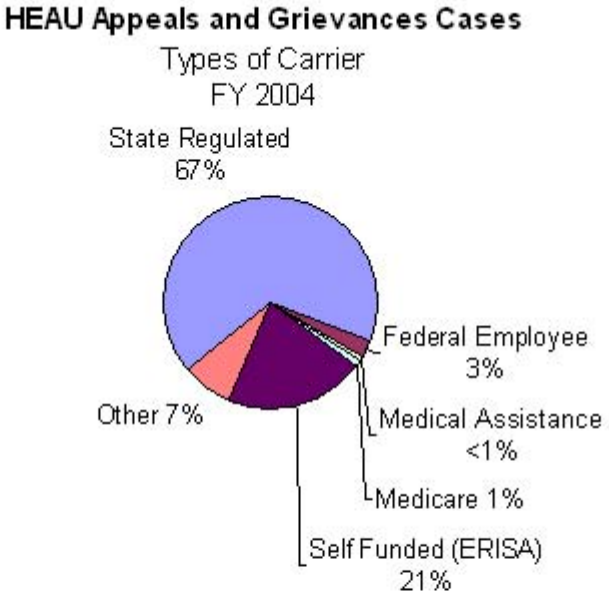
The above chart identifies the types of services involved in Appeals and Grievances cases mediated by HEAU during FY 2004.

Outcomes of Cases by Type of Service
FY 2004

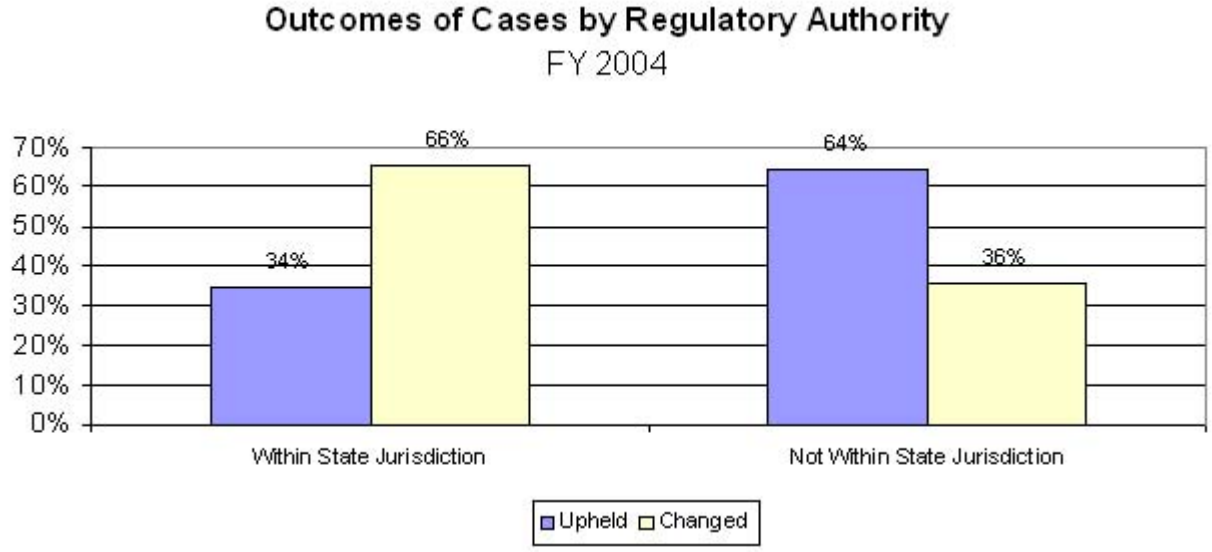


This chart shows the outcomes of Appeals and Grievances cases mediated by HEAU during FY 2004. It shows how the outcome varies based upon the types of services involved in the cases. Cases resulting in carriers overturning or modifying adverse decisions have been combined for this chart.

* In both of the above charts, Other includes: Acupuncture, Chiropractic, Habilitative Services, Home Health, Optometry, Products and Supplements, Skilled Nursing Facility, Transport and Other cases where the Type of Service did not fit an existing category.

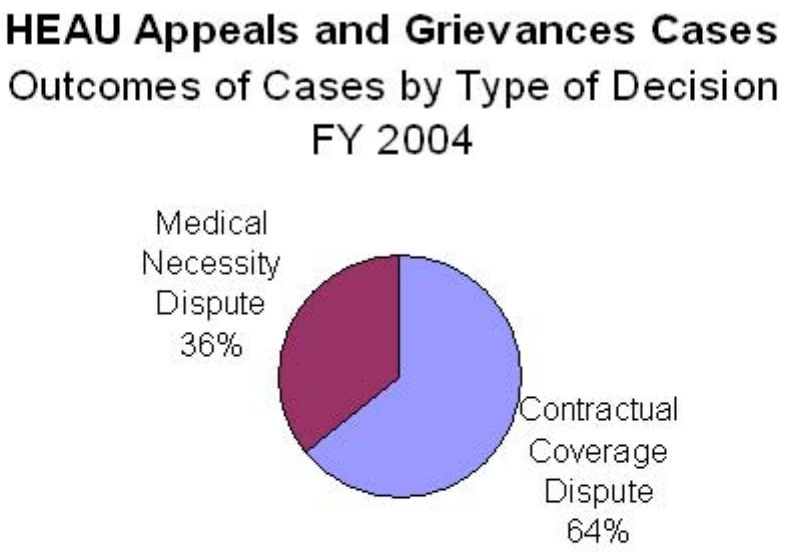


The above chart identifies the types of carriers involved in the Appeals and Grievances cases mediated by HEAU during FY 2004.

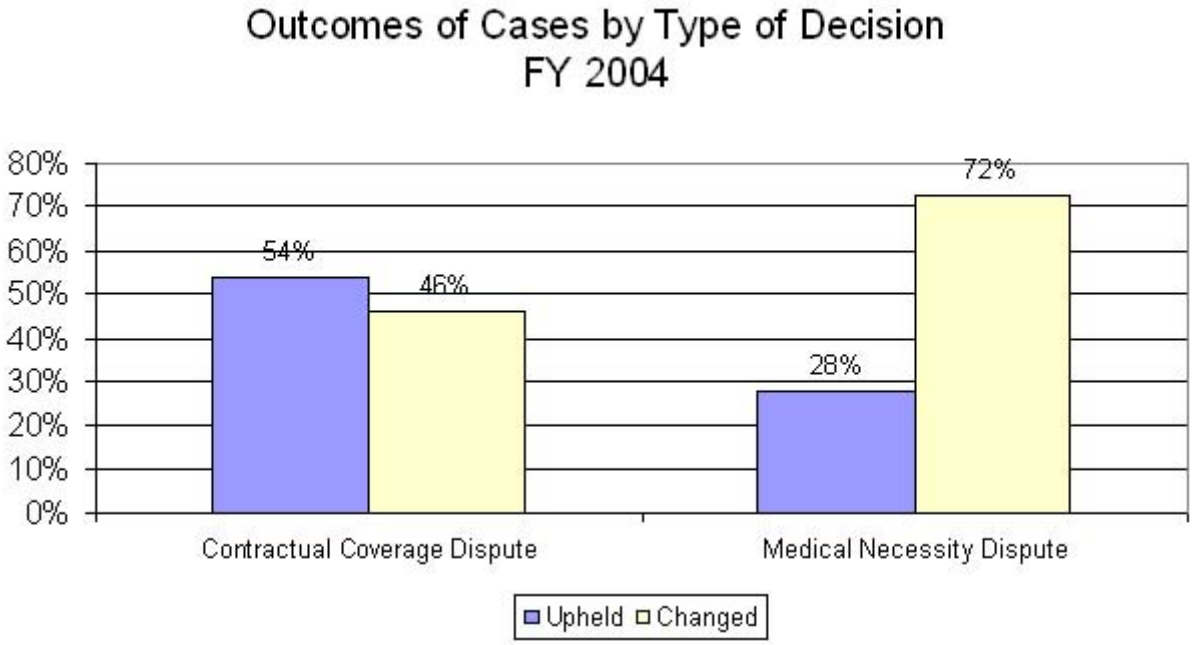


This chart shows the outcomes of Appeals and Grievances cases mediated by HEAU during FY 2004. It shows how the outcome varies based upon whether the carrier is within state jurisdiction*.

* Carriers not within state jurisdiction include Self-insured, Federal Employee, Medical Assistance, Medicare, Military and Out-of-State plans.



The above chart identifies the percentage of medical necessity and contractual coverage disputes for the Appeals and Grievances cases mediated by HEAU during FY 2004.



This chart compares the outcomes of medical necessity and contractual coverage disputes.