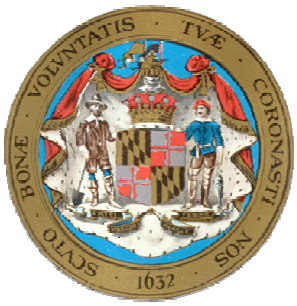

State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

Prepared by:
HEALTH EDUCATION AND ADVOCACY UNIT
CONSUMER PROTECTION DIVISION
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 the 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] The HEAU is required to issue a report each November that summarizes the grievances and complaints handled by carriers, the HEAU, and the Maryland Insurance Administration (MIA). The 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 those processes.

This is the second report issued by the HEAU since the passage of the Appeals and Grievances Law during the 1998 General Assembly session. The first report, issued November 1999, described the first several months of implementation of the Appeals and Grievances Law and made recommendations for improving the system. As required by statute, this report will cover grievances and complaints handled during the state fiscal year 2000, beginning July 1, 1999 and concluding on June 30, 2000.

The Appeals and Grievances Law is evaluated by:

- Summarizing the provisions of the law;
- Updating changes to the law since the 1999 annual report;
- Discussing implementation efforts of the health insurance carriers, HEAU and MIA;
- Presenting a statistical summary of grievances and complaints handled by carriers, the HEAU, and MIA;
- Identifying grievances related to mental health and substance abuse care to be least likely to be resolved in carrier internal grievance processes and evaluating potential reasons why this is true; and,
- Discussing the problems encountered by patients with grievances who are enrolled in federally regulated plans.

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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.

The following observations can be made about Maryland's Appeals and Grievances Law:

- The consumer assistance role filled by the Health Education and Advocacy Unit is an essential element in the success of the Appeals and Grievances Law.

- The presence of the MIA with its authority to overturn carriers' decisions is a necessary element in creating responsive grievance and appeal systems.

- The Appeals and Grievances Law in Maryland is designed to significantly limit patient barriers to access available assistance remedies.

- Patients have seen an increased responsiveness from health insurance carriers.

While the Appeals and Grievances Law is generally working well, the report identifies the following areas of concern:

- Marylanders in plans that are exempt from the provisions of the Appeals and Grievances Law, and more specifically those in self-insured plans regulated by the Employee Retirement Income Security Act (ERISA), do not share in the benefits available to those patients enrolled in state regulated plans.

- Patients seeking a reversal of an adverse decision related to mental health or substance abuse treatment are not benefitting from system changes brought about by the law.

- Deadlines placed on patients remain significant barriers to patient access.

- The quality of the available data must continue to improve.

II. Overview of the Appeals and Grievances Process

The 1998 General Assembly passed the Appeals and Grievances Law to provide patients with an enhanced ability to resolve disputes with their health insurance carriers regarding denials of coverage by carriers.

The process outlined in the Appeals and Grievances Law begins with an adverse decision issued to the patient by the carrier. An **adverse decision** is a written decision by a health insurance carrier that proposed or delivered health care services are not medically necessary, appropriate, or efficient. After receiving an adverse decision, a patient[3] may file a grievance through the carrier's **internal grievance process**. The Health Education and Advocacy Unit (HEAU) is available to attempt to mediate the dispute or, if necessary, to help patients file grievances with carriers. The carrier has a specified time frame to review a grievance, thirty working days for a grievance involving pending care and forty-five working days for a grievance involving care that has already been rendered. At the conclusion of the internal grievance process, the carrier informs the patient of the outcome in a written **grievance decision**.

A patient may appeal the grievance decision to the Maryland Insurance Administration (MIA**)** for an **external review** of the carrier's decision. In most cases, patients must exhaust the carrier's internal grievance process prior to filing a complaint with MIA. However, patients may file a complaint with MIA without exhausting the internal grievance process when there is a compelling reason not to go through the internal grievance process.

[3] 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. Improvements to the Appeals and Grievances Process

During the past year, there have been several legislative enhancements that will benefit Maryland patients. The following discussion highlights the major improvements:

Expansion of Appeals and Grievances Process

The experience of the HEAU has demonstrated that there are two primary limitations preventing Marylanders from utilizing the full range of state services available in the appeals and grievances process. First, many patients are covered by plans not subject to state regulation because their plans are exclusively within the jurisdiction of the federal government (see discussion, page 15). Second, patients have been unable to challenge denials unless they were based on the medical necessity of the care in question. While state legislators are limited in their ability to respond to the problem of plans not subject to state regulation, the Maryland General Assembly passed legislation during the 2000 Session that allows patients to dispute a wide range of claims determinations through the appeals and grievances system.

The legislation, passed as HB 405 and entitled "Complaint Process of Coverage Decision"[4] establishes an appeals and grievances process for patients to challenge other coverage decisions that do not involve the "medical necessity" definition contained in the original Appeals and Grievances Law. The new law will allow patients to challenge any carrier's decision that results in total or partial non-coverage or non-provision of a health care service.

The new law creates a parallel process to the existing Appeals and Grievances Law including a requirement of written notices of decisions from carriers, assistance from the HEAU in appealing carrier decisions, requirements that patients exhaust internal appeal mechanisms unless care is urgently needed, requirements that carriers clearly state the basis of their decisions, and external appeal to the MIA following exhaustion of the carrier's appeal process. One significant difference between the new process for challenging coverage decisions from that in place for medical necessity decisions is that patients have significantly longer deadlines to appeal grievance decisions to the MIA (a provision the HEAU recommends be extended to medical necessity appeals as well). These new provisions will take effect on January 1, 2001.

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

Notice to Patients

The 1999 report noted that patients were often confused by the written notices sent by carriers. Legislation passed by the 2000 General Assembly addresses these issues. Beginning October 1, 2000 the law requires carriers to include information about the assistance available from the HEAU and MIA on the original adverse decision. Previously, carriers only had to provide that information to a patient who contacted the carrier to challenge the adverse decision. These changes assure that all patients receiving adverse decisions will receive information about how to challenge decisions and, if desired, how to obtain assistance in doing so.

Carrier Data

The complaint data that carriers submit quarterly to the MIA provides basic information about the results of the carriers' internal grievance processes. However, the 1999 Annual Report identified several problems with that data, including incomplete and inconsistent reporting of data by carriers. Beginning in January 2000, the MIA changed the form that carriers use to report the quarterly report data. The new reporting form has resulted in more consistency and more complete data being reported by the carriers. While we remain concerned that the data does not contain some basic information that would make it much more valuable (see discussion of carrier data on page 6), the usefulness of the data has been enhanced.

IV. 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 covered by the requirements of the law.[5] For those plans regulated by the state, the Appeals and Grievances Law establishes guidelines that the carriers must follow in notifying patients of denials based upon medical necessity, establishing a grievance process, and notifying members of grievance decisions. The law subjects carrier decisions to an external review by MIA. In addition, the Appeals and Grievances Law requires carriers to submit quarterly reports to the MIA that describe the number and outcomes of internal grievances handled by the carriers.

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. Instead, carriers categorize their data and report limited data within each category. Therefore, standards of reporting and categorizing may vary significantly from one carrier to another making it difficult to compare one carrier's data to that of another.

- Carriers are required to report grievances filed by their members. However, they are not required to report any information about adverse decisions that are issued. Therefore, it is impossible to determine the percentage of decisions that are appealed for various types of services.

- 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 some 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. Because 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.

[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.

Carrier Statistics FY 2000

In addition to the highlights listed below, charts providing statistical detail of the data reported by carriers appear on pages 21-26 of this report.

- Carriers reported receiving 4069 grievances from their members during FY 2000.

- Overall, carriers change their original adverse decisions in nearly 51% of the grievances they receive, overturning adverse decisions in 46% of cases and modifying them in 5%. This is a drop of 9% from FY 1999, when carriers reported changing nearly 60% of their adverse decisions during their internal grievance processes.

- The outcomes of internal grievances vary significantly based upon the type of service that is the subject of the dispute. For example, adverse decisions involving emergency room services (73%) and pharmacy services (72%) are much more likely to be overturned or modified during grievance processes than adverse decisions involving mental health services (31%) and inpatient hospital services (35%).

- Most of the data reported by carriers in FY 2000 reflects similar variances based upon the type of service involved as those reported during FY 1999, with denials of mental health services again being the least likely to be overturned during the grievance process.

- One notable difference between FY 2000 and FY 1999 was that the percentage of grievances involving inpatient hospital services that were overturned or modified during the grievance process fell from 52% during FY 1999 to 35% reported during FY 2000.

Notable Trends - Mental Health and Substance Abuse Treatment

In a continuation of a trend described in the 1999 HEAU Annual Report, patients challenging adverse decisions related to mental heath and substance abuse are less likely to have a carrier change its original decision through the internal grievance process than patients challenging other types of medical service decisions. According to data supplied by carriers regarding 6,105 grievances reported since January 1, 1999, only 30% of grievances involving adverse decisions related to mental health care were overturned or modified during the carrier internal grievance process compared to 58% of grievances involving adverse decisions related to other types of care.

Concern regarding the disparity in the outcomes is heightened because mental health care is disproportionately represented as a type of service about which patients file grievances. Carriers reported a total of 735 mental health cases between January 1999 and June 2000, representing 12% of all carrier reported grievances. However, mental health care represents only 3-5% of the health care services provided in the state. Therefore, the data reported by carriers shows that patients seeking mental health care are more likely to file a grievance related to an adverse decision, but less likely to have the carrier's internal grievance process change the adverse decision.

The disparity in overturned or modified rates is even more dramatic when grievances related to substance abuse are examined. HEAU reviewed the diagnostic codes supplied by carriers in their grievance reports and found that carriers overturn or modify adverse decisions in only 16% of grievances in which the patient's diagnosis is related to substance abuse.[6] In an effort to understand the disparity in outcomes encountered in the mental health and substance abuse grievances, HEAU looked for differences between mental health and substance abuse treatment, and other services types. Toward that goal HEAU considered the following questions:

1. Upon what do the decision makers base their determinations for mental health and substance abuse services? Upon what do the decision makers base their determinations for other services types?

    - The key to most successful grievances is the ability of the patient and provider to demonstrate that the patient's condition meets the utilization criteria used by the carrier to decide when certain types of care are necessary. When the criteria list specific medical conditions that must be met, patients and their health care providers may provide information to the carrier in the form of test results or other observations that will demonstrate that the patient needs the requested service. However, when the criteria are vague, subjective, and less measureable, establishing that those criteria have been met becomes more difficult.

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[6]HEAU identified Substance Abuse and Mental Health ICD9 codes based on *HEDIS 2000 Technical Specification*. Substance abuse ICD9 codes utilized were 291-292, and 303-305. Mental Health ICD9 codes utilized were 209, 293-302, and 306-316.

- In most medical care decisions, carriers and utilization managers can use standardized criteria and readily identifiable measures such as results of blood tests, presence of dependence upon IV drugs, body mass index measures and other similar elements to make coverage decisions. The criteria for utilization management decisions related to mental health and substance abuse care typically involve less measurable patient condition indicators and a greater level of subjectivity on the parts of both the health care provider and the reviewer. Mental health and substance abuse care often involves measures of progress of a patient that are ambiguous and that may vary significantly during the course of a long-term treatment plan.

- Difficulties related to the application of mental health utilization criteria were highlighted in a recent report from the National Association of Attorneys General on managed care's impact on substance abuse treatment. That report stated:

> "One problem identified is the ambiguity present in many of the contracts for alcohol and drug addiction treatment. If the contracts are required to carry established treatment criteria, and if standards for contracting language are established, some access problems could be solved and the ability of the managed care plan to use ambiguities to escape treatment requirements would be lost."[7]

- An example of emergency room service criteria draws a contrast between services where clear and specific criteria are available and those where the criteria are vague or subjective. For treatment in emergency rooms the State and federal statutes have established a "prudent layperson" standard that may be applied throughout the insurance industry in reviewing decisions related to the appropriate use of an emergency room. It has been the experience of the HEAU that this common standard simplifies the appeal process. As a result, grievances related to emergency room treatment are overturned or modified in 73% of cases reported by carriers and in 81% of the cases handled by the HEAU.

- The following needs to be determined about mental health and substance abuse criteria: Are there more specific, measurable, and standardized criteria readily available for mental health and substance abuse medical necessity determinations? Can episodic mental health and substance abuse treatments be managed with standardized criteria? Can communication between carriers and providers be improved to foster better exchange of criteria and patient condition information?

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[7]National Association of Attorneys General, "Alcohol & Drug Addiction Treatment Under Managed Care: A Prosecutorial Perspective, August 2000, page xx.

2. Who makes the coverage and grievance decisions for mental health and substance abuse services? Who makes the coverage and grievance decisions for other service types?

- Mental health services are far more likely than medical services to be "carved out" to utilization management entities. In many instances, not only has the utilization review function been delegated to an independent utilization review entity, but the internal grievance process has been delegated to the utilization review agent as well. Therefore, the original decisions to deny services, and the grievance processes for patients to challenge those decisions, may be isolated from the health insurance carrier.

- While the health insurance carriers bear the final responsibility for assuring the appeals and grievances processes of the managed behavioral health organizations (MBHOs)[8] they contract with, the MBHOs essentially manage their own autonomous processes. It has been HEAU's experience that most MBHOs resolve all behavioral health complaints internally without any observable carrier intervention.

- It should be noted that there is currently no data available directly from the MBHOs related to the grievances they handle because the data related to particular MBHOs is included in the various contracting carrier's grievance reports. This makes it impossible for HEAU to evaluate grievance outcomes for cases handled by specific MBHOs.

- The following needs to be determined about mental health and substance abuse MBHOs: What percent of carriers carve out mental health and substance abuse benefits? Are there differences in grievance outcomes for carriers who do not carve out? Are there differences between the individual MBHO's regarding grievance outcomes?

While these questions are by no means an exhaustive review of mental and substance abuse issues, they do highlight specific situations repeatedly encountered by the HEAU during the mediation process. Standardized written criteria for medical necessity decisions appear to be needed. In addition, comprehensive data collection and reporting of the internal grievance processes for mental health and substance abuse patients, including reporting by MBHOs, are needed to better understand these troubling patterns.

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[8]*Managed behavioral health care organizations* are defined as "a company, organization, or subsidiary that: contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to members; or otherwise makes behavioral health care services available to members through contracts with mental health care providers."

V. Maryland Insurance Administration

The Maryland Insurance Administration (MIA) is the regulator of insurance products offered in the State of Maryland. In the Appeals and Grievances Law, the General Assembly provided additional resources for the MIA to handle an increased caseload, including the authority to contract with medical experts to conduct reviews of the adverse decisions of health insurance carriers. The law also gives the MIA the specific authority to conduct these external reviews, and assigns the MIA responsibilities and deadlines for cases involving urgently needed care.

When the MIA receives a written complaint, it reviews it to determine if the complaint raises issues that are subject to the Appeals and Grievances Law. If it does, then the MIA determines if the internal grievance process has been exhausted, or if it appears that a compelling reason exists to not exhaust the process. If the grievance process has not been exhausted and no compelling reason exists to bypass the internal grievance process, the MIA refers the case to the HEAU. If the internal process has been exhausted or if a compelling reason to bypass the internal grievance process is identified, the MIA will contact the carrier in writing within five working days requesting a written response to the complaint. In the carrier's written response to the MIA, it may confirm or reverse its denial or provide additional information related to the complaint.

If the carrier confirms a denial that is subject to the Appeals and Grievances Law, then the MIA investigator will prepare the file for review by an independent review organization (IRO). As part of this preparation, the investigator will contact the appropriate parties in writing, asking them to send any additional medical documentation they wish to submit within a certain time period. If a consent form has not yet been signed by the patient, the MIA will obtain one at this time.

Once the proper documentation is received by the MIA, the file is forwarded to an IRO for review. The appropriate parties, including the carrier, are notified of such action simultaneously. The IRO is asked to respond to specific questions set forth in a cover letter. If the Insurance Commissioner agrees with an IRO's recommendation to overturn the carrier's denial, an order is issued and forwarded to the carrier along with a notice that the carrier has the right to request a hearing to challenge the order. At the same time, the patient or provider who filed the complaint is notified of the outcome by telephone, if possible, and then by mail. If the Insurance Commissioner agrees with an IRO's recommendation to uphold the carrier's denial, the patient or provider is informed of the decision by phone, if possible, and is informed that s/he has the right to request a hearing. The carrier is also informed of this decision by phone, if warranted, and by mail.

An expedited external review process is available when a patient or provider contacts the MIA regarding urgently needed care. A hotline number (1-800-492-6116) is available 24 hours/7 days a week to respond to these emergency cases. The MIA completes the above process within 24 hours for emergency cases.

MIA Statistics FY 2000

In addition to the highlights listed below, charts providing statistical detail of the disposition of MIA cases appear on pages 27-31 of this report.

- The Appeals and Grievances Unit of the MIA reviewed a total of 1581 cases that were filed between July 1, 1999 and June 30, 2000.

- After reviewing these cases, the MIA determined that 569 involved adverse decisions issued by health insurance carriers regulated by the MIA.

- MIA referred 282 of the 569 adverse decision complaints to the 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 grievances process.

- MIA initiated reviews of 287 cases in which patients challenged grievance decisions issued by health insurance carriers. Carriers reversed their grievance decisions in 148 of these cases before the MIA issued an order.

- MIA issued 139 orders related to appeals and grievances cases during FY2000 with 68 (49%) upholding, 65 (47%) overturning, and 6 (4%) modifying carriers' grievance decisions.

- Including cases reversed by carriers during the MIA review process, a total of 219 (76%) of the 287 cases on which MIA initiated reviews resulted in changes to carriers' grievance decisions.

VI. The Health Education and Advocacy Unit

The Health Education and Advocacy Unit was established by an act of the 1986 General Assembly and assigned the primary tasks of assisting health care consumers in understanding their health care bills and third party coverage; identifying improper billing or coverage determinations; reporting billing and/or coverage problems to appropriate agencies; and assisting patients with health equipment warranty issues. To fulfill these responsibilities, the HEAU built upon the established mediation program of the Consumer Protection Division of the Attorney General's Office. Based upon the HEAU's successful use of mediation to resolve patient disputes with health care providers and health insurance carriers, the General Assembly entrusted the HEAU as the first line consumer assistance agency in the appeals and grievances process.

Health insurance carriers must notify patients that the HEAU is available to assist them if they wish to appeal an adverse decision. Patients appealing a carrier's decision can obtain assistance by calling the HEAU's toll-free hotline (1-877-261-8807). The HEAU, in cooperation with the MIA, conducted several outreach programs to patient and provider organizations to increase public awareness of the patient and provider rights and resources afforded by the Appeals and Grievances Law. Many patients and providers who contact the HEAU hotline indicate that they learned of these services through the Unit's outreach and education efforts.

The HEAU gathers basic information from a patient and from the patient's health care provider about the patient's condition and the service that the plan has denied. The health insurance carrier is also contacted and requested to provide the utilization review criteria upon which the carrier's decision to deny care was based and to indicate which of those criteria the patient's condition failed to meet. Additional information is gathered from the patient and treating providers to document that the patient meets the criteria established by the health plan. The HEAU presents this information to the carrier for a reconsideration of the denial.

If the carrier continues to deny the care and the patient or provider wishes to pursue the matter, the HEAU transfers the case file to the MIA, complete with all medical documentation obtained during the mediation efforts. Except in emergency cases the patient or provider must exhaust the carrier's internal grievance process before the MIA may review a case.

HEAU Statistics FY 2000

In addition to the highlights listed below, charts providing statistical detail of the disposition of HEAU cases appear on pages 32-42 of this report.

- The HEAU closed 2083 cases from July 1, 1999 through June 30, 2000, representing a 150% increase in complaints from the number closed by the Unit prior to the implementation of the Appeals and Grievances Law.

- Of the 2083 cases closed by the HEAU, 1385 (66%) were filed against health insurance carriers. The HEAU determined that 884 (64%) of the 1385 cases filed against health insurance carriers related to patients challenging adverse decisions.[9]

- Based upon a comparison to data reported by carriers, patients who seek assistance from the HEAU during the grievance process are far more likely to have the adverse decision changed during that process than those patients who file grievances on their own. Carriers reported changing 51% of adverse decisions during the grievance process while the HEAU efforts resulted in adverse decisions being changed in 76% of the cases mediated involving carriers subject to MIA regulation.

- Mediation efforts resulted in changes to carrier decisions in 54% of the cases that were filed against carriers not subject to review by MIA.

[9]Adverse decisions are those decisions made by health insurance carriers that health care services are not medically necessary, appropriate or efficient.

Continuing Issue - Cases Not Subject to State Regulation

Approximately 25% of the appeals and grievances cases handled by the HEAU involve carriers that are exempt from state regulation because they involve employer self-insured plans. These plans are subject only to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). The assistance efforts of the HEAU resulted in self-insured plans changing their original adverse decision in 54% of the cases. This rate was significantly lower than for cases involving carriers subject to state regulation where HEAU assistance efforts resulted in 76% of those adverse decisions being changed by carriers.

The differences in outcomes reflect the differences in state and federal requirements, since in all other respects, these two groups of cases are the same. The federal requirements under ERISA are not nearly as comprehensive as those provided under Maryland's Appeals and Grievances Law. While ERISA prescribes uniform minimum standards to ensure that employee benefit plans are fair, financially sound, and provide workers with other benefits promised by their employers, it does not require a standardized grievance process. In fact, the ERISA internal grievance process need not be provided in the insurance contract. Rather, ERISA requires only "adequate notice" of a claim denial and a "reasonable opportunity" for a full and fair review of a grievance.[10] There is no federally provided resource to assist the patient during the appeal process and, while the Federal Department of Labor enforces what standards are present in ERISA, there is no external review of medical necessity decisions as is provided in Maryland.

While they are not required to do so, almost all self-insured plans will engage in mediation with the HEAU to resolve patient grievances. However, unlike plans covered by state regulation, carriers are not compelled to respond to the HEAU within certain time frames and are not required to provide utilization review criteria to patients, providers, or the HEAU. Many self-insured plans will provide basic information to the HEAU during the grievance process, but often do not provide utilization criteria in response to HEAU requests, thus limiting the HEAU's ability to structure a grievance based upon the criteria used by the plan. These limitations, particularly when combined with the absence of an external review of carriers' decisions, account in large part for the significant differences in outcomes for self-insured cases as compared to state-regulated cases.

While the HEAU services may offer assistance to patients in self-insured plans, change at the federal level is required to provide comprehensive assistance to patients with disputes with self-insured plans. Key provisions of Maryland's Appeals and Grievances Law, including disclosure of criteria, minimum grievance process standards and time lines, external review of decisions, and disclosure of grievance data must be made applicable to these cases if Marylanders enrolled in these plans are to enjoy similar benefits as do those who are enrolled in plans currently subject to the Appeals and Grievances Law.

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[10]Employee Retirement Income Security Act of 1974, Pub L. No. 93-406, 88 Stat.829 (1974) (codified as amended in 29 U.S.C. § 1133(1994)).

VII. Conclusion

This is the second report on the Appeals and Grievances Law issued by the HEAU. It is based on both the HEAU's experience during the initial eighteen months this law has been in effect and the experience of the carriers and the MIA during the same period of time. While our data is somewhat limited by both the period of time over which it has been collected as well as by the method that some of it has been collected, we have begun to identify trends and indicators of the effectiveness of the law and its implementation. In addition, at least 32 states had implemented some form of health insurance appeals and grievances system as of March 2000.[11] We can also use comparative studies of those various state systems as a tool for evaluating the effectiveness of the Maryland system. Based upon the available information, the following observations about the Maryland Appeals and Grievances Law can be made:

Positive Notes

1. The consumer assistance role filled by the HEAU is an essential element to the success of the Appeals and Grievances Law.

Data submitted by carriers and collected from HEAU cases demonstrates that patients who utilize the services of the HEAU during the carrier internal grievance process have a better chance of having the adverse decision changed during the grievance process than those patients who file grievances without assistance. The differences are most dramatic in areas such as mental health (31% vs. 54%) and inpatient hospital stays (35% vs. 65%) where some patients may be limited in their capacity to successfully file a grievance with their carrier.

A report issued by Georgetown University in June 2000 highlighted the ombudsman's role played by the HEAU and similar agencies in some other states as especially important in an effective appeals and grievances system:

> "Independent ombudsman or consumer assistance programs are essential in ensuring accountability of state insurance regulatory agencies and in providing an alternative, more approachable forums for consumer complaints. They can also play a vital role in resolution of consumer complaints through mediation and in undertaking systemic advocacy based on complaint analysis. The independence and accountability of ombudsman programs need to be fostered through statutory authority, dedicated funding and a requirement for reporting to the legislature and general public."[12]

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[11]Geraldine Dallek and Karen Pollitz, "External Review of Health Plan Decisions: An Update," prepared for the Kaiser Family Foundation, May 2000, Page 3.

[12]Sharon Wilcox, "Consumer Protection and Private Insurance: The Role of Consumer Complaints," prepared for the US Department of Health and Human Services.

2. *The presence of an effective state regulatory effort, such as that provided by the MIA, is a necessary element in creating responsive grievance and appeal systems.*

As we highlight on page 15, the cases handled by the HEAU in which the grievance decision was not subject to the external review provided through the MIA were significantly less likely to result in carriers changing their original decisions to deny claims for services. The value of MIA's efforts, therefore, is reflected both in the outcomes of cases handled directly by that agency and in the effect that the presence of its review process has on cases that are resolved without having to be filed with the MIA.

3. The appeals and grievances system in Maryland is designed to significantly limit patient barriers to patient access to available assistance and remedies.

A study of 32 state processes identified several barriers to patient access that have been erected in other states. Some of those barriers include minimum claims thresholds, limits by the type of carrier decision in dispute, and filing fees.[13] Fortunately, the General Assembly rejected adding such barriers to Maryland's system and the recent expansion of the types of decisions subject to review makes the system accessible to even more patients.

4. Patients may have seen an increased responsiveness from health plans.

While it is relatively simple to quantify the numbers of patients helped by the direct assistance efforts of the HEAU and the external reviews conducted by the MIA, it is much more difficult to determine what type of impact the Appeals and Grievances Law has on the health insurance industry as a whole and, consequently, on patients who may not contact the HEAU or MIA for assistance. However, the HMO report issued by the Maryland Health Care Commission in 2000 may provide some insight:

> "In 1999, the Maryland HMO average for members who reported they were satisfied with how their complaints were resolved was 56 percent. In 2000, this satisfaction rate increased to 75 percent. When comparing absolute rates, the majority of plans reported improvements that were statistically significant. This 19 percent change was the largest change in CAHPS-related Maryland HMO averages and shows a major improvement. Some changes in the complaint satisfaction process may be attributable to the implementation of Maryland's appeals and grievances legislation in January 1999 which requires all plans to have an internal appeal process as well as the opportunity for external review."[14]

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[13]Geraldine Dallek and Karen Politz, Pages 4-6.

[14]Maryland Health Care Commission, "2000 Comprehensive Performance Report: Commercial HMOs in Maryland," page IV-110.

Areas of Concern

While the appeals and grievances process is helping many Marylanders, challenges remain that must continue to be addressed and monitored by implementing agencies and the General Assembly. Those challenges include:

1. Patients in plans exempt from the provisions of the Appeals and Grievances Law, and specifically those in ERISA plans, do not share in the benefits available to patients enrolled in state regulated plans.

While the HEAU provides assistance in the form of mediation services to members of self-insured plans, those efforts are much less likely to result in a favorable outcome to the patient than similar efforts to assist patients in state-regulated plans. We must continue to explore possibilities to assist more fully Marylanders enrolled in these plans.

2. Patients seeking a reversal of an adverse decision related to mental health or substance abuse treatment are not benefitting from the Appeals and Grievances Law.

As discussed on pages 8-10, overturn rates for adverse decisions related to mental health and substance abuse are significantly lower than those rates for other types of services. We must continue to explore the reasons for this discrepancy by collecting and evaluating additional data regarding these cases and by seeking input from carriers, providers, and patients.

3. Deadlines placed on patients remain as significant barriers to patient access.

We continue to recommend that patients be extended more time to appeal adverse decisions to carriers and to the MIA. Carriers should not be permitted to limit the opportunity of a patient to appeal a decision through its internal grievance process by a restrictive time limit. In addition, it seems inappropriate that the most restrictive non emergency-related deadline in the entire appeals and grievances process (30 calendar days) is placed upon patients who wish to appeal a grievance decision to MIA. We recommend a significant extension of this statutory deadline. Extending this deadline to 180 days would benefit patients and not treat the other parties unfairly. But, at a minimum, the deadline should be extended to at least the 60 working days provided to patients disputing coverage decisions.

4. The quality of the data available must continue to improve.

We have highlighted on page 6 limitations to the usefulness of carrier data due to how and what data is collected. Additionally we indicated in our discussion of mental health and substance abuse, data related to "carve out" organizations responsible for conducting utilization management and handling grievances related to their decisions must also be

collected. If the available data was improved in these two ways, both the HEAU and the MIA could provide both the public and policymakers with a clearer picture of what is taking place in Maryland's health care marketplace.

Appendix

Carrier Grievance Data

Grievances Reported by Carriers

Fiscal Year 2000

Carrier	Upheld		Overturned		Modified		Total
Aetna US Healthcare, Inc. (DE)	89	39%	136	59%	5	2%	230
AIG Life Insurance Company	0	0%	0	0%	1	100%	1
Allianz Life Insurance Co. of North America	0	0%	1	100%	0	0%	1
American Republic Insurance Company	5	100%	0	0%	0	0%	5
Ameritas Life Insurance Corporation	18	72%	6	24%	1	4%	25
CapitalCare, Inc	3	43%	3	43%	1	14%	7
CareFirst of Maryland Inc.	154	56%	120	43%	3	1%	277
Celtic Life Insurance Company	4	100%	0	0%	0	0%	4
CIGNA Dental Health of Maryland	0	0%	8	100%	0	0%	8
CIGNA Healthcare Mid-Atlantic, Inc.	4	13%	19	59%	9	28%	32
Companion Life Insurance Company	0	0%	1	100%	0	0%	1
Connecticut General Life Insurance Company	67	40%	88	52%	10	6%	168
Continental	30	39%	45	59%	1	1%	76
Continental Casualty Company	2	33%	2	33%	2	33%	6
Coventry Health Care of Delaware	1	17%	5	83%	0	0%	6
Delmarva Health Plan, Inc.	37	80%	8	17%	1	2%	46
Dental Benefit Providers, Inc.	2	100%	0	0%	0	0%	2
Educators Mutual Life Insurance Company	2	40%	1	20%	2	40%	5
Employers Health Insurance Compnay	1	100%	0	0%	0	0%	1
Employers Insurance of Wausau	0	0%	1	100%	0	0%	1
Fidelity Security Life Insurance Company	9	24%	29	76%	0	0%	38

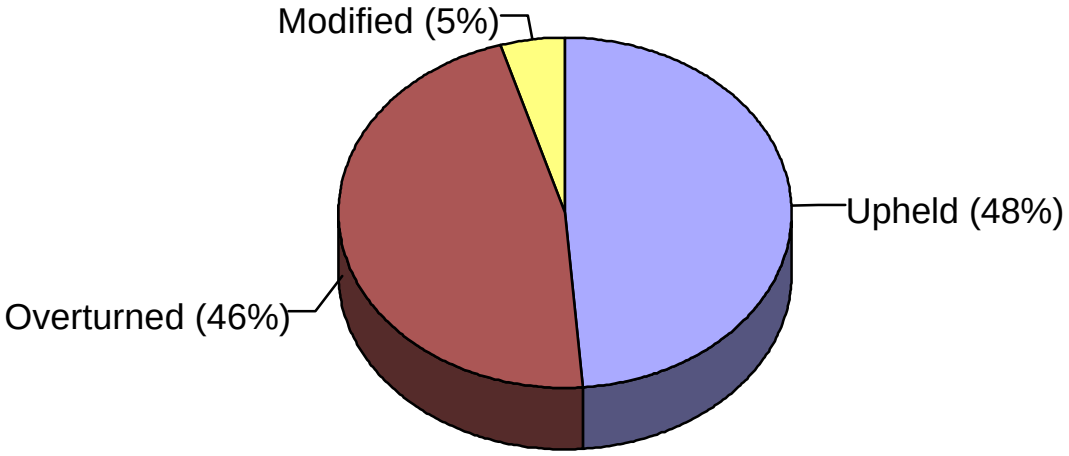
Carrier	Upheld		Overturned		Modified		Total
Freestate Health Plan, Inc.	154	65%	81	34%	2	1%	237
General American Life Insurance Company	0	0%	1	100%	0	0%	1
George Washington University Health Plan	4	29%	9	64%	1	7%	14
Great West Life and Annuity Insurance Company	1	13%	7	88%	0	0%	8
Group Hospitalization and Medical Services, Inc. T/A Carefirst Blue Cross Blue Shield	18	60%	11	37%	1	3%	30
Guardian Life Insurance Company	9	64%	4	29%	1	7%	14
Health Care 2000, Inc.	15	36%	23	55%	4	10%	42
Household Life Insurance Company	3	100%	0	0%	0	0%	3
Innovation Health Inc.	4	20%	11	55%	1	5%	20
Kaiser Foundation	72	20%	289	80%	0	0%	361
MAMSI Life and Health Insurance Company	162	46%	174	49%	17	5%	353
Maryland Fidelity Insurance Company	30	38%	44	56%	5	6%	79
MD-Individual Practice Association, Inc.	138	67%	55	27%	12	6%	205
Mutual of Omaha Insurance Company	12	80%	3	20%	0	0%	15
Nationwide Life Insurance Company	0	0%	2	100%	0	0%	2
New England Life Insurance Company	0	0%	2	100%	0	0%	2
One Health Plan of New Jersey, Inc. (ONE)	1	50%	1	50%	0	0%	2
Optimum Choice, Inc.	348	57%	235	38%	30	5%	613
Pacific Life and Annuity	4	19%	16	76%	1	5%	21
Phoenix American Life Insurance Company	1	100%	0	0%	0	0%	1
Pioneer Life Insurance Company	2	100%	0	0%	0	0%	2
Preferred Health Network	25	41%	15	25%	12	20%	61
Provident American Life and Health	1	20%	2	40%	1	20%	5

Carrier	Upheld		Overturned		Modified		Total
Prudential HealthCare	188	45%	208	50%	22	5%	418
Prudential Insurance Company of America	0	0%	2	67%	1	33%	3
Reliastar Life Insurance Company	2	50%	2	50%	0	0%	4
Spectera Dental Services, Inc.	3	60%	2	40%	0	0%	5
Trustmark Insurance Company	15	68%	6	27%	1	5%	22
UNICARE Life and Health Insurance Company	0	0%	0	0%	0	0%	3
Union Labor Life Insurance Company	2	100%	0	0%	0	0%	2
United Benefit Life	0	0%	0	0%	0	0%	1
United Concordia Dental Plans, Inc.	8	29%	18	64%	2	7%	28
United Concordia Life and Health Insurance Company	0	0%	3	100%	0	0%	3
United Health Care of the Mid-Atlantic	175	60%	99	34%	18	6%	292
United HealthCare Insurance Company	15	63%	3	13%	6	25%	24
United of Omaha Life Insurance Company	30	71%	12	29%	0	0%	42
United Wisconsin Life Insurance Company	102	53%	76	40%	13	7%	191
Total	**1972**	**48%**	**1889**	**46%**	**187**	**5%**	**4069**

Carrier Grievance Data

Outcomes of Internal Grievances

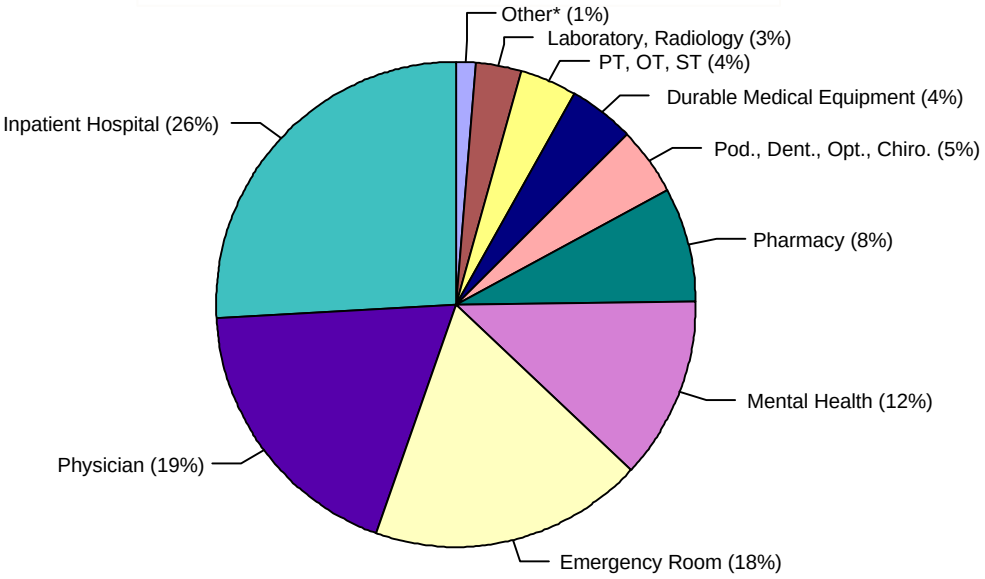
FY 2000



This chart describes the outcomes of the 4069 internal grievances as reported by carriers during FY 2000.

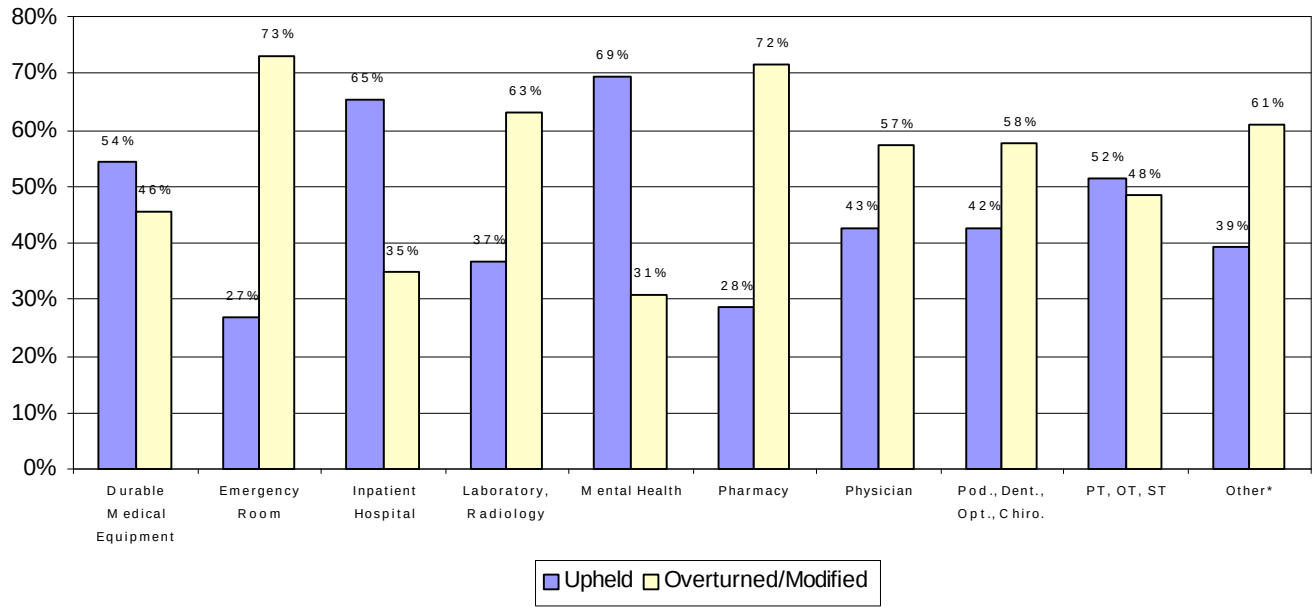
Carrier Grievance Data

Type of Service Involved in Grievances
FY 2000



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 2000.

Outcomes of Grievances by Type of Service
FY 2000

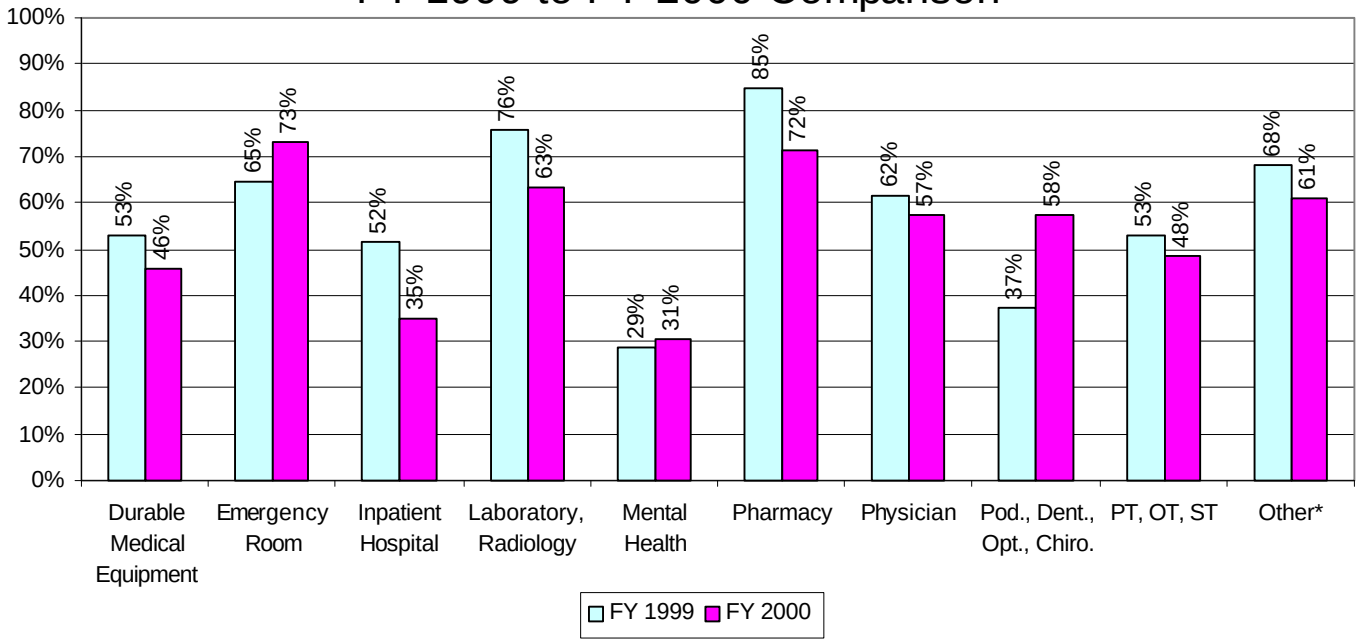


Carriers are required to identify the type of service involved in the internal grievances they receive as well as the outcomes of those grievances. This chart compares the variance in the outcome of grievance based upon the type of service being disputed in the grievance. This chart is based upon carrier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

* Includes Home Health (.71%), Skilled Nursing Facility, Sub Acute Facility, Nursing Home (.29%) and Other or Unknown (.32%).

Carrier Grievance Data

Percentage of Grievances Overturned or Modified
FY 1999 to FY 2000 Comparison



Carriers have been reporting their internal grievance data since January 1, 1999. This chart compares the percentage of cases reported as overturned or modified during FY 1999* to the percentage of cases reported as overturned or modified during FY 2000.

* FY 1999 includes only 6 months of data reported for January to June 1999.

MIA Appeals and Grievances Complaints

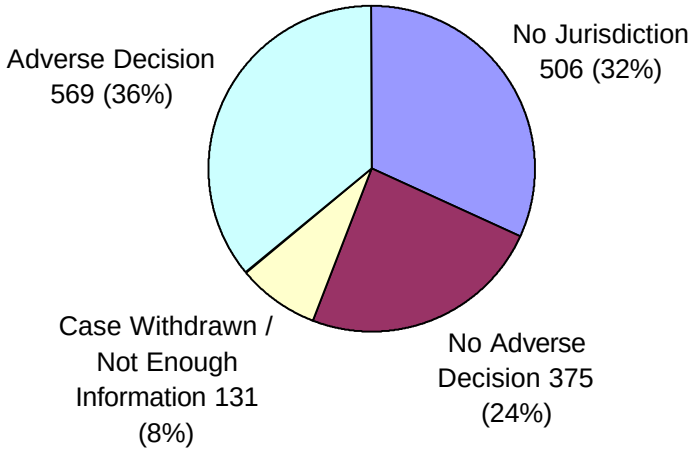
Complaints Listed by Carrier

FY 2000

Carrier	Total	Carrier Upheld by MIA		Carrier Reversed by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
Aetna U.S. Healthcare, Inc.	23	2	9%	3	13%	0		18	78%
American Medical Security Ins. Co.	6	2	33%	0		0		4	67%
Ameritas	1	0		0		1	100%	0	
BCBS of MD	68	13	19%	17	25%	1	1%	37	54%
Capital Care	3	1	33%	0		0		2	67%
CIGNA	10	3	30%	4	40%	0		3	30%
Connecticut General	1	1	100%	0		0		0	
Coventry Health Care of DE	1	0		1	100%	0		0	
Delmarva Health Plan	2	0		1	50%	0		1	50%
Educator's Mutual	1	1	100%	0		0		0	
Freestate Health Plan	35	10	29%	6	17%	1	3%	18	51%
Group Hospitalization & Med Serv	5	2	40%	2	40%	0		1	20%
Guardian Life Insurance Co.	5	1	20%	1	20%	0		3	60%
George Washington Univ. Health	1	0		0		0		1	100%
Humana Group	2	0		0		0		2	100%
Innovation Health	1	0		0		1	100%	0	
Kaiser Permanente	15	4	27%	3	20%	2	13%	6	40%
MAMSI	21	10	48%	5	24%	0		6	29%
Maryland Fidelity	3	2	67%	0		0		1	33%
MD IPA	8	3	38%	3	38%	0		2	25%
Metropolitan Life	1	0		0		0		1	100%
Mutual of Omaha	1	0		0		0		1	100%
NYLCare	4	0		0		0		4	100%
Optimum Choice, Inc.	23	5	22%	11	48%	0		7	30%
PHN HMO	4	3	75%	0		0		1	25%
Prudential HealthCare, Inc.	27	4	15%	7	26%	0		16	59%
Unicare Life	1	0		0		0		1	100%
Union Fidelity	1	0		0		0		1	100%
Union Labor Life	1	0		0		0		1	100%
United HealthCare	9	0		0		0		9	100%
United of Omaha	1	0		0		0		1	100%
United Wisconsin Life	2	1	50%	1	50%	0		0	
TOTAL	**287**	**68**	**24%**	**65**	**23%**	**6**	**2%**	**148**	**52%**

MIA Complaints

Complaints Reviewed by Appeals and Grievances Unit FY 2000



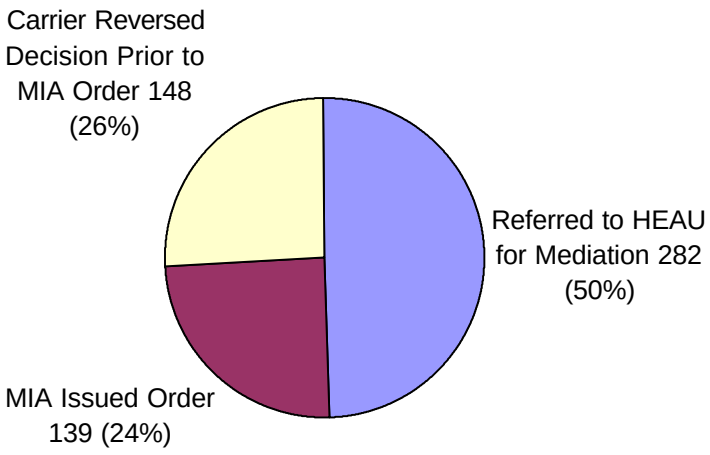
When the MIA Appeals and Grievances Unit receives a written complaint, it reviews it to determine:

- 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 available to complete the review. This chart details the outcome of MIA's review of 1581 cases during FY 2000.

MIA Appeals and Grievances Complaints

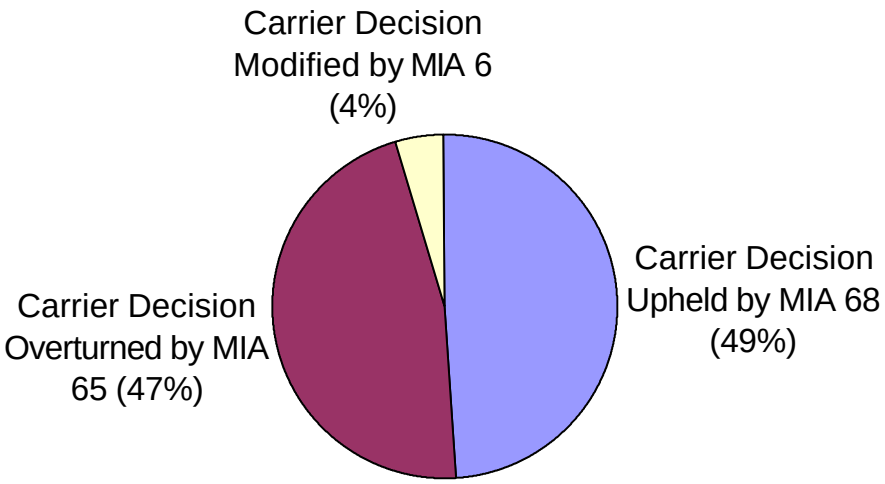
Disposition of Complaints
FY 2000



During FY 2000, MIA determined that 569 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 the HEAU. The remaining cases were either resolved by carriers during the MIA review process or resulted in an MIA order.

MIA Appeals and Grievances Complaints

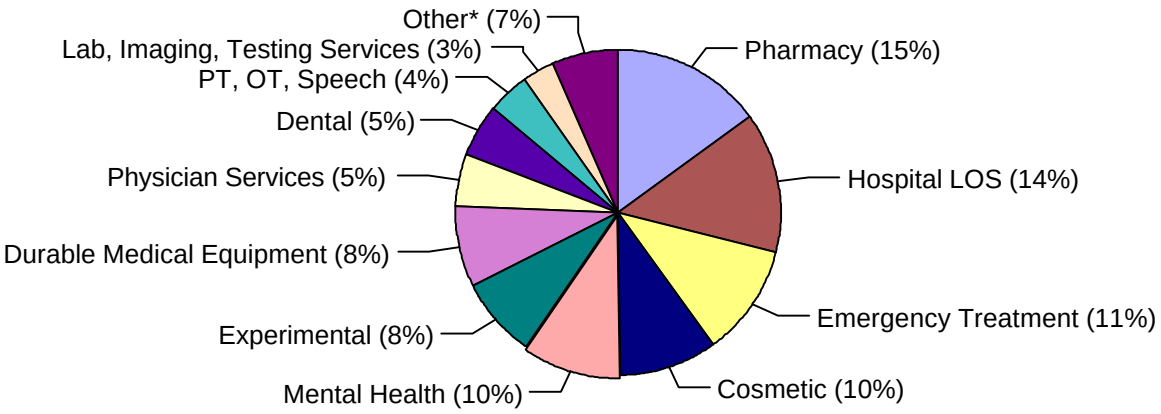
Results of MIA Orders
FY 2000



MIA issued 139 orders related to Appeals and Grievances Complaints during FY 2000. This chart describes the outcomes of those orders.

MIA Appeals and Grievances Complaints

Type of Service Involved in Complaints
FY 2000



The above chart identifies the types of services involved in Appeals and Grievances Complaints handled by the MIA during FY 2000.

* Includes In-Patient Rehabilitation, Chiropractic, Eye Care, PCP Referral, Home Health Care Skilled Nursing and Nutritional Evaluation.

Outcomes of Complaints by Type of Service
FY 2000

Type of Procedure	Total	Carrier Upheld by MIA		Carrier Reversed by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
Pharmacy	43	3	7%	1	2%	0		39	91%
Hospital Length of Stay	40	11	28%	15	38%	0		14	35%
Emergency Treatment	32	2	6%	9	28%	1	3%	20	63%
Cosmetic	28	7	25%	12	43%	0		9	32%
Mental Health	28	6	21%	5	18%	1	4%	16	57%
Experimental	23	14	61%	5	22%	0		4	17%
Durable Medical Equipment	23	7	30%	9	39%	0		7	30%
Physician Services	15	1	7%	3	20%	1	7%	10	67%
Dental	15	3	20%	1	7%	1	7%	10	67%
PT, OT, Speech	12	6	50%	1	8%	0		5	42%
Lab, Imaging, Testing Services	9	0		1	11%	0		8	89%
PCP Referrals	5	3	60%	0		0		2	40%
In-Patient Rehabilitation	4	2	50%	1	25%	1	25%	0	
Chiropractic	4	1	25%	1	25%	1	25%	1	25%
Eye Care	3	2	67%	0		0		1	33%
Home Health Care	1	0		1	100%	0		0	
Skilled Nursing	1	0		0		0		1	100%
Other (Nutritional Evaluation)	1	0		0		0		1	100%
TOTAL	**287**	**68**	**24%**	**65**	**23%**	**6**	**2%**	**148**	**52%**

This chart shows the outcomes of Appeals and Grievances Complaints handled by the MIA during FY 2000. 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 2000

		Overturned/Modified		Upheld		All Relief
Aetna US Healthcare	Not State Regulated	14	67%	7	33%	21
	State Regulated	17	85%	3	15%	20
	Total HEAU Complaints	**31**	**76%**	**10**	**24%**	**41**
Alliance	Not State Regulated	2	50%	2	50%	4
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**2**	**50%**	**2**	**50%**	**4**
Blue Cross Blue Shield of Maryland	Not State Regulated	2	67%	1	33%	3
	State Regulated	4	80%	1	20%	5
	Total HEAU Complaints	**6**	**75%**	**2**	**25%**	**8**
Blue Cross Blue Shield Of Pennsylvania	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Blue Cross Blue Shield of the National Capital Area	Not State Regulated	4	50%	4	50%	8
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**5**	**56%**	**4**	**44%**	**9**
CareFirst, Inc.	Not State Regulated	24	50%	24	50%	48
	State Regulated	42	75%	14	25%	56
	Total HEAU Complaints	**66**	**63%**	**38**	**37%**	**104**
CIGNA	Not State Regulated	9	60%	6	40%	15
	State Regulated	7	88%	1	13%	8
	Total HEAU Complaints	**16**	**70%**	**7**	**30%**	**23**
CIGNA Healthcare for Seniors	Not State Regulated	4	67%	2	33%	6
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**4**	**67%**	**2**	**33%**	**6**
Connecticut General Life Insurance Company	Not State Regulated	6	67%	3	33%	9
	State Regulated	2	100%	0	0%	2
	Total HEAU Complaints	**8**	**73%**	**3**	**27%**	**11**
CoreSource, A Trustmark Company	Not State Regulated	1	50%	1	50%	2
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**50%**	**1**	**50%**	**2**
Delmarva Health Plan	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	1	100%	1
	Total HEAU Complaints	**0**	**0%**	**2**	**100%**	**2**

		Overturned/Modified		Upheld		All Relief
Educators Mutual Life	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
FELRA & UFCW Health and Welfare Fund	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Fidelity Insurance	Not State Regulated	3	50%	3	50%	6
	State Regulated	4	80%	1	20%	5
	Total HEAU Complaints	**7**	**64%**	**4**	**36%**	**11**
First Allmerica Insurance Company	Not State Regulated	2	100%	0	0%	2
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**2**	**100%**	**0**	**0%**	**2**
Fortis Health Insurance Company	Not State Regulated	0	0%	0	0%	0
	State Regulated	0	0%	1	100%	1
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Freestate Health Plan	Not State Regulated	7	41%	10	59%	17
	State Regulated	17	71%	7	29%	24
	Total HEAU Complaints	**24**	**59%**	**17**	**41%**	**41**
George Washington University Health Plan	Not State Regulated	0	0%	1	100%	1
	State Regulated	5	100%	0	0%	5
	Total HEAU Complaints	**5**	**83%**	**1**	**17%**	**6**
Government Employees Hospital Association (GEHA)	Not State Regulated	0	0%	3	100%	3
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**3**	**100%**	**3**
Great West Life Insurance	Not State Regulated	1	100%	0	0%	1
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**2**	**100%**	**0**	**0%**	**2**
Group Benefit Services, Inc.	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Guardian Insurance Company	Not State Regulated	0	0%	0	0%	0
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Healthcare 2000	Not State Regulated	1	50%	1	50%	2
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**50%**	**1**	**50%**	**2**

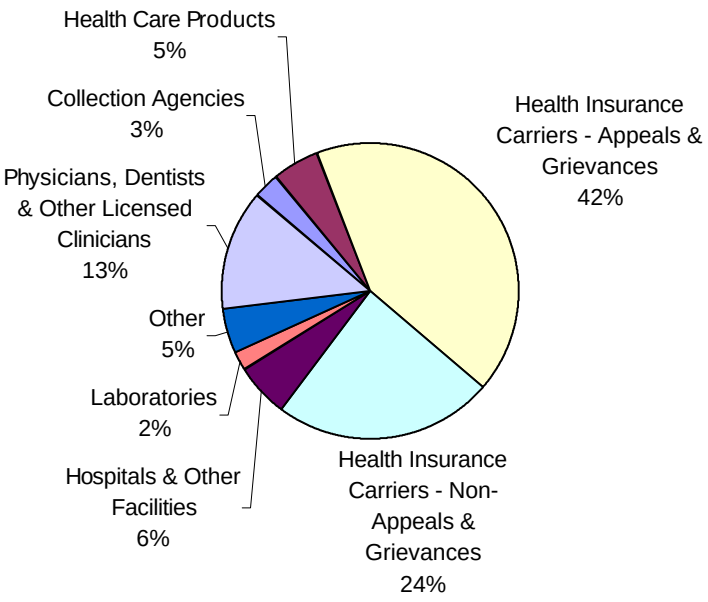
		Overturned/Modified		Upheld		All Relief
Healthcare Strategies	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Horizon Blue Cross Blue Shield of New Jersey	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Humana Employers Health	Not State Regulated	2	100%	0	0%	2
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**2**	**100%**	**0**	**0%**	**2**
Innovation Health Inc	Not State Regulated	0	0%	0	0%	0
	State Regulated	0	0%	1	100%	1
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Johns Hopkins Employee Health Plan	Not State Regulated	3	60%	2	40%	5
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**3**	**60%**	**2**	**40%**	**5**
Kaiser Permanente	Not State Regulated	4	57%	3	43%	7
	State Regulated	8	80%	2	20%	10
	Total HEAU Complaints	**12**	**71%**	**5**	**29%**	**17**
Kaiser Senior Select Program	Not State Regulated	1	33%	2	67%	3
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**33%**	**2**	**67%**	**3**
Mail Handlers Benefit Plan	Not State Regulated	2	100%	0	0%	2
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**2**	**100%**	**0**	**0%**	**2**
MAMSI Life & Health Insurance Company	Not State Regulated	2	40%	3	60%	5
	State Regulated	7	70%	3	30%	10
	Total HEAU Complaints	**9**	**60%**	**6**	**40%**	**15**
MDIPA	Not State Regulated	1	33%	2	67%	3
	State Regulated	5	71%	2	29%	7
	Total HEAU Complaints	**6**	**60%**	**4**	**40%**	**10**
Medicare	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Medicare Complete of United Healthcare	Not State Regulated	8	89%	1	11%	9
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**8**	**89%**	**1**	**11%**	**9**

		Overturned/Modified		Upheld		All Relief
MediCareFirst	Not State Regulated	9	43%	12	57%	21
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**9**	**43%**	**12**	**57%**	**21**
National Prescription Administrators, Inc.	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Nylcare	Not State Regulated	12	92%	1	8%	13
	State Regulated	20	80%	5	20%	25
	Total HEAU Complaints	**32**	**84%**	**6**	**16%**	**38**
O'Neill Consulting	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Optimum Choice	Not State Regulated	3	38%	5	63%	8
	State Regulated	12	57%	9	43%	21
	Total HEAU Complaints	**15**	**52%**	**14**	**48%**	**29**
Physicians Mutual Insurance	Not State Regulated	0	0%	0	0%	0
	State Regulated	0	0%	1	100%	1
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Preferred Health Network	Not State Regulated	1	33%	2	67%	3
	State Regulated	7	78%	2	22%	9
	Total HEAU Complaints	**8**	**67%**	**4**	**33%**	**12**
Principal Health Care	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Prudential HealthCare	Not State Regulated	11	46%	13	54%	24
	State Regulated	22	88%	3	12%	25
	Total HEAU Complaints	**33**	**67%**	**16**	**33%**	**49**
Sheppard Pratt Health Plan	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Shore Medical Service	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Sierra Military Health Service	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**

		Overturned/Modified		Upheld		All Relief
Sinai Care, Inc.	Not State Regulated	0	0%	0	0%	0
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
State Farm Insurance	Not State Regulated	0	0%	0	0%	0
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Union Labor Life Insurance	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
United Concordia Companies, Inc.	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
United Healthcare of the Mid-Atlantic	Not State Regulated	3	30%	7	70%	10
	State Regulated	9	64%	5	36%	14
	Total HEAU Complaints	**12**	**50%**	**12**	**50%**	**24**
United Wisconsin Life Insurance Company	Not State Regulated	2	100%	0	0%	2
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**3**	**100%**	**0**	**0%**	**3**
Upper Chesapeake Health System	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Willse & Associate	Not State Regulated	2	100%	0	0%	2
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	2	100%	0	0%	2
Total	**Not State Regulated**	**154**	**54%**	**130**	**46%**	**284**
	State Regulated	**194**	**76%**	**62**	**24%**	**256**
	Total HEAU Complaints	**348**	**64%**	**192**	**36%**	**540**

HEAU Cases

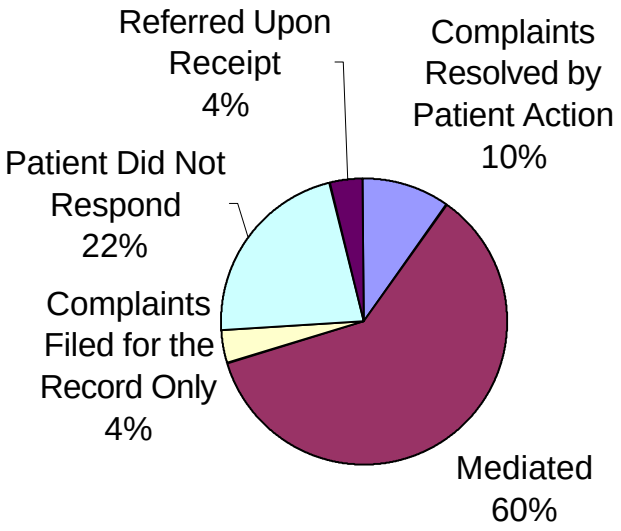
Who Are Cases Filed Against?
FY 2000



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 the 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 the HEAU during FY 2000.

HEAU Appeals and Grievances Cases

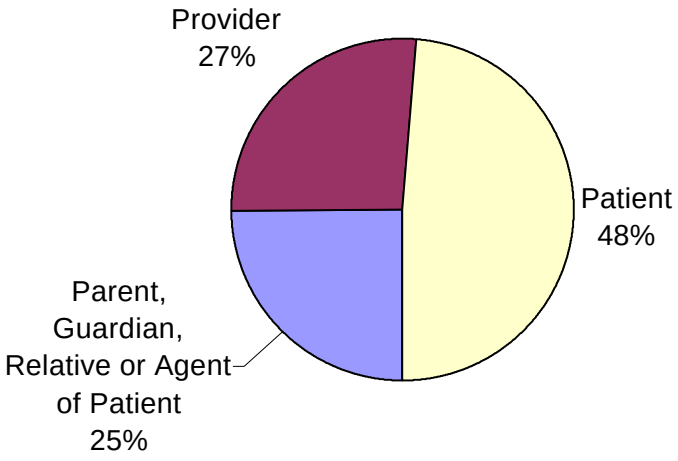
Disposition of Cases
FY 2000



The HEAU closed 900 cases related to patients who disputed carrier adverse decisions. However, not all of these cases were mediated by the 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. In 22% of the cases, patients did not respond to the HEAU's request for additional information, most often by not providing a form authorizing carriers and providers to release information to the HEAU. This chart shows the disposition of all Appeals and Grievances cases closed by the HEAU during FY 2000.

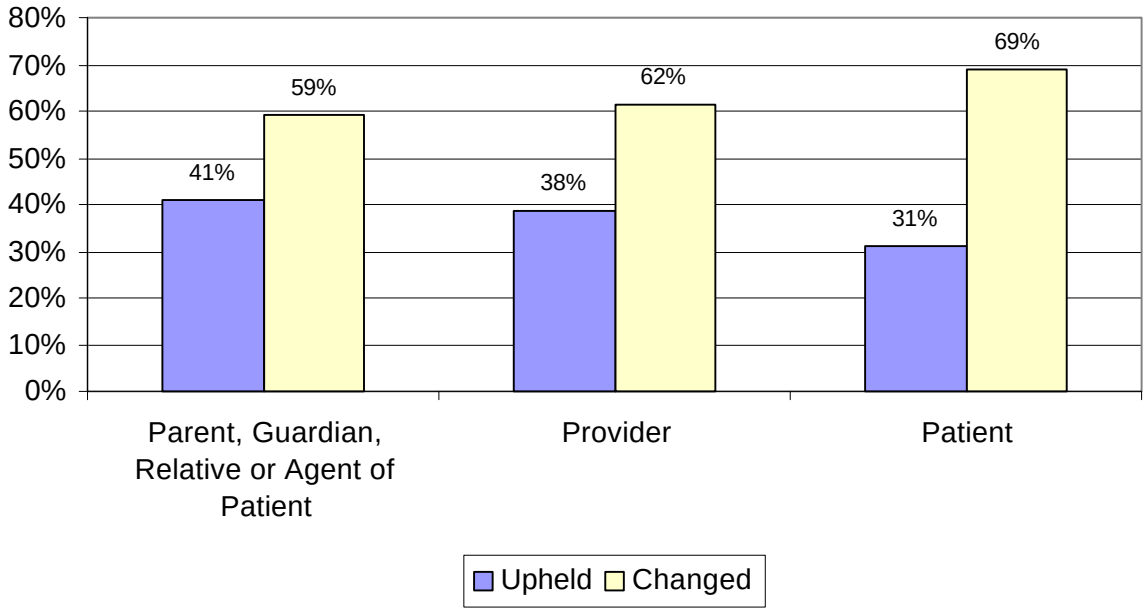
HEAU Appeals and Grievances Cases

Who Filed Case?
FY 2000



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 the HEAU and shows that just over half are filed by someone who is assisting the patient.

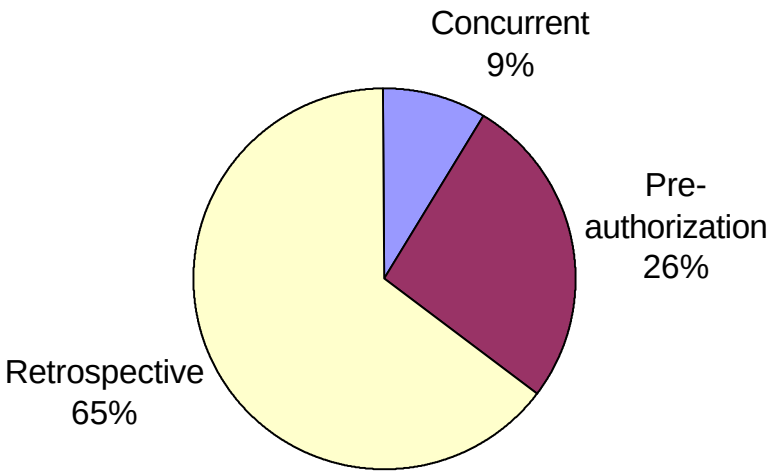
Outcomes Based Upon Who Filed Case
FY 2000



This chart shows the outcome of Appeals and Grievances Cases mediated by the HEAU during FY 2000. It shows the outcome of the case varies slightly based upon who filed the cases, with the highest overturned rate reported on cases filed by patients themselves. Cases resulting in carriers overturning or modifying adverse decisions have been combined for this chart.

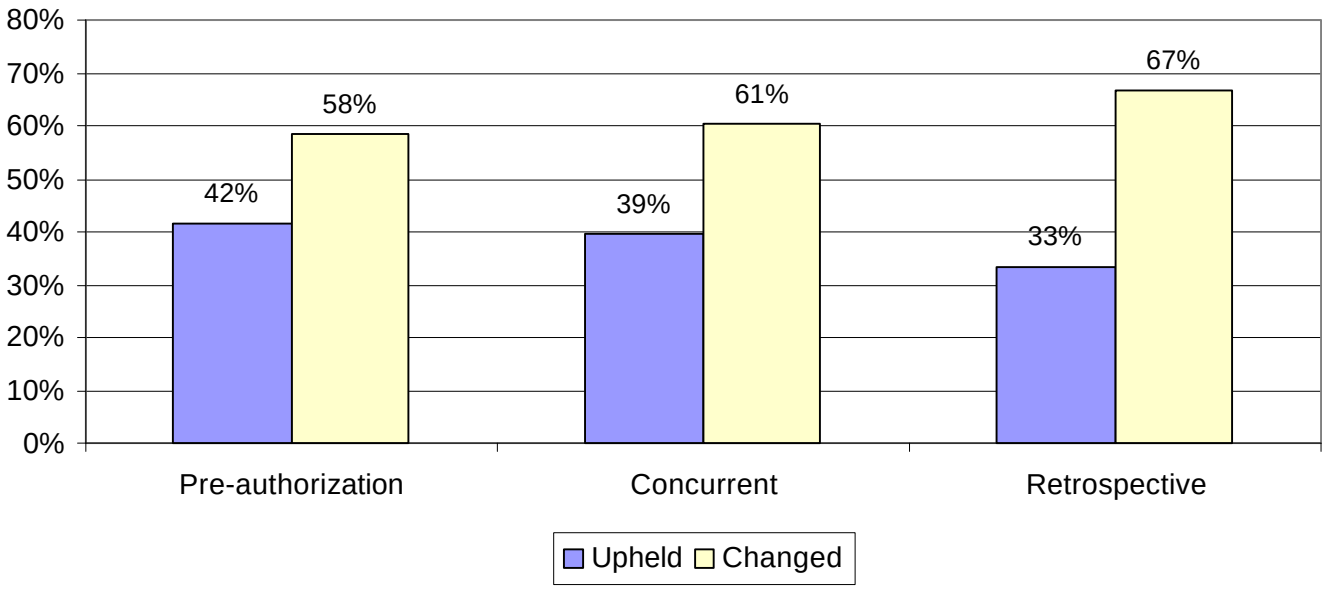
HEAU Appeals and Grievances Cases

Timing of Adverse Decision
FY 2000



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 the HEAU during FY 2000.

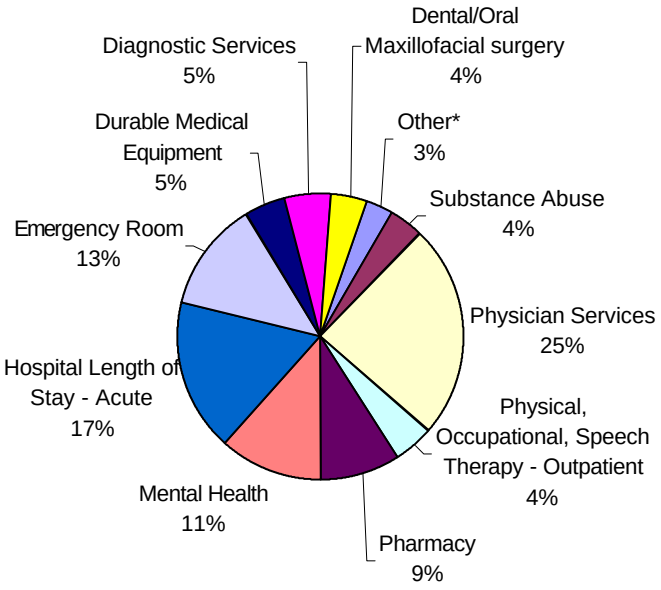
Outcomes Based Upon Timing of Adverse Decision
FY 2000



This chart shows the outcomes of Appeals and Grievances Cases mediated by the HEAU during FY 2000. It shows that the outcome of cases vary only slightly based upon when the adverse decision was issued in relationship to the treatment. Cases resulting in carrier overturning or modifying adverse decisions have been combined fo this chart.

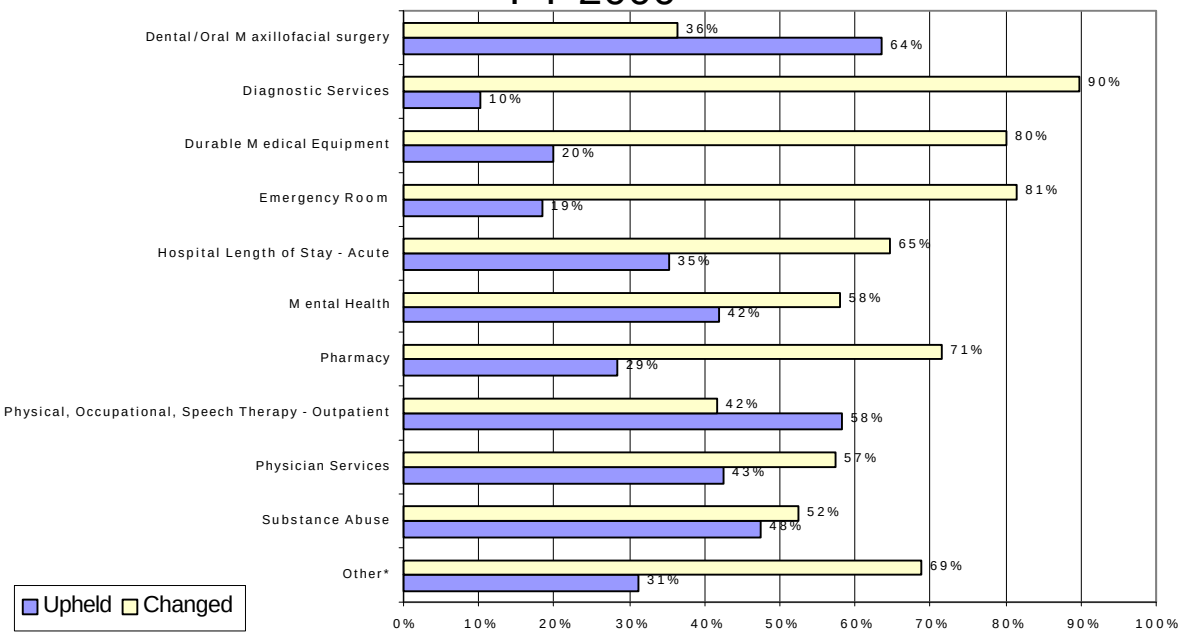
HEAU Appeals and Grievances Cases

Type of Service Involved in Cases
FY 2000



The above chart identifies the types of services involved in Appeals and Grievances cases mediated by the HEAU during FY 2000.

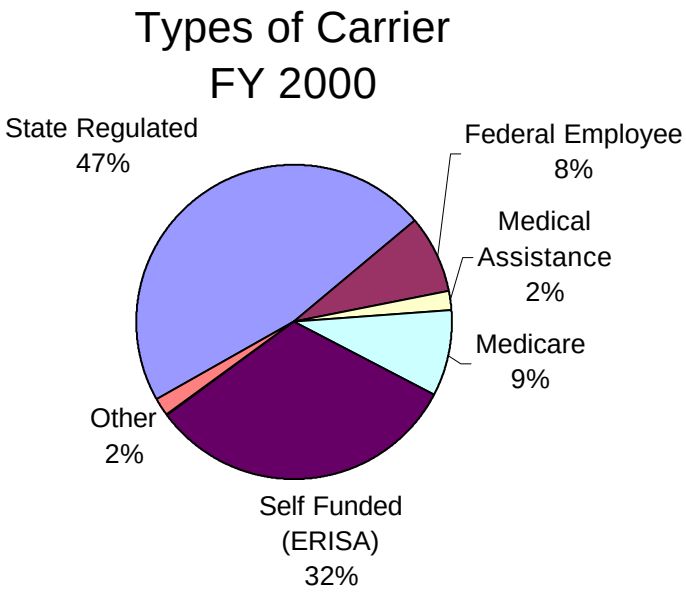
Outcomes of Cases by Type of Service
FY 2000



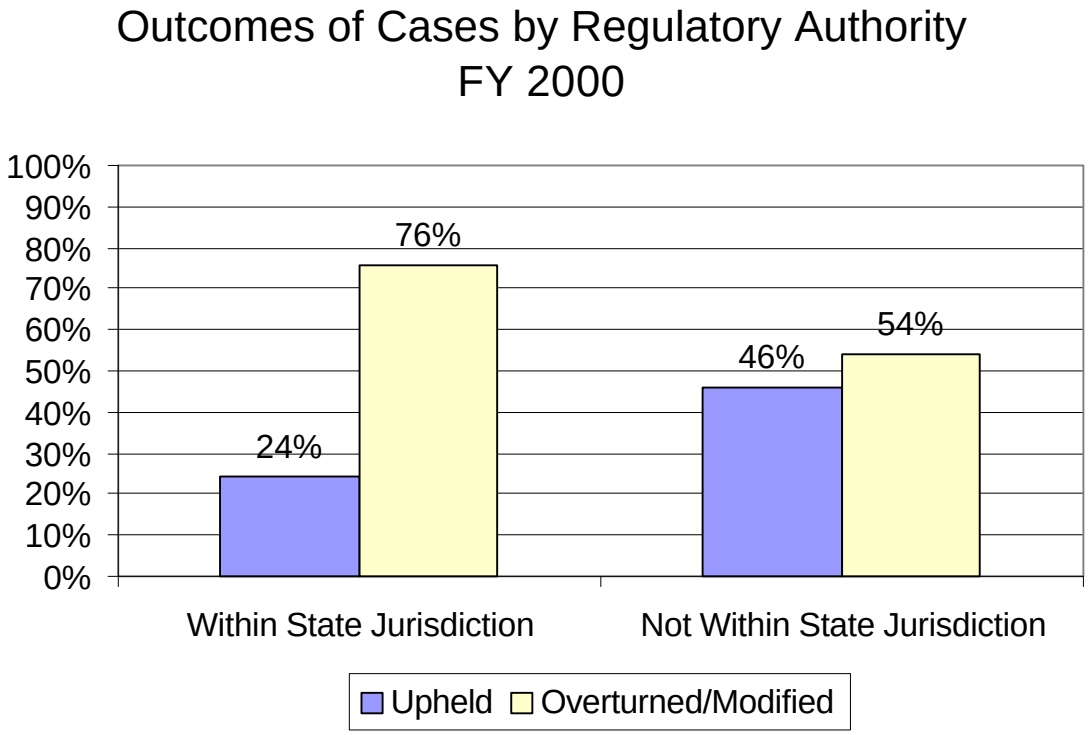
This chart shows the outcomes of Appeals and Grievances cases mediated by the HEAU during FY 2000. It shows how the outcome varies based upon the types of services involved in the cases. Cases resulting in carriers overturning or modifying adverse decisions have been combined for this chart.

* In both of the above charts, Other includes: Chiropractic, Podiatry, Products and Supplements, Skilled Nursing Facility, Inpatient Physical Rehabilitation - Subacute stay, Optometry and Other cases where the Type of Service did not fit an existing category.

HEAU Appeals and Grievances Cases



The above chart identifies the types of carriers involved in the Appeals and Grievances cases mediated by the HEAU during FY 2000.



This chart shows the outcomes of Appeals and Grievances cases mediated by the HEAU during FY 2000. It shows how the outcome varies based upon whether the carrier is within state jurisdiction*. Cases resulting in carriers overturning or modifying adverse decisions have been combined for this chart.

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