State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

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OFFICE OF THE ATTORNEY GENERAL

Submitted to the Governor and General Assembly

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I. Executive Summary

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

This report covers grievances and complaints filed or referred during State Fiscal Year 2016, beginning July 1, 2015 and concluding on June 30, 2016.

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

II. Overview of the Appeals and Grievances Process

State Law

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

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

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

[2] The Appeals and Grievances Law defines "carrier" as (1) an authorized issuer that provides health insurance in the State, (2) nonprofit health service plan, (3) health maintenance organization, (4) dental plan, or (5) any other person that offers a health benefit plan subject to regulation by the State.

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

[4] Chapters 3 and 4 made other changes to processes and rights under the Appeals and Grievances Law that became effective July 1, 2011.

in the rescission of an individual's coverage. As a result, since July 1, 2011, patients in Maryland can challenge any decision by a carrier that results in the total or partial denial of a covered health care service, the denial of eligibility for coverage, or the rescission of coverage.

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

Federal Law

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

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

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

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

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

III. Phases of the Appeals and Grievances Process

For both adverse decisions and coverage decisions, the appeals and grievances process starts when a patient receives notice from the carrier that the carrier has rendered an adverse decision or coverage decision. Carriers must provide patients with a written notice that clearly states the basis of the carrier's adverse or coverage decision and that the HEAU is available to mediate the dispute with the carrier or, if necessary, help the patient file a grievance or appeal.

[5] 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 23, 2010).
[6] 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 26, 2011).

The notice must also inform the patient that an external review of the decision is available through the MIA or other external reviewer following exhaustion of the carrier's internal process. Patients may file a complaint with the MIA or other external reviewer prior to exhausting the internal grievance process only when there is a compelling reason.

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

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

IV. Carrier Reporting

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

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

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

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

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

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

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

Carrier Statistics FY 2016

In addition to the highlights below, charts providing statistical detail from the data submitted by the carriers appear on pages 13-21 of this report.

1. Carriers reported 54,722 adverse decisions in FY 2016, 11,446 more adverse decisions than reported in FY 2015. Ten carriers reported increases in adverse decisions of greater than 100%. CareFirst of Maryland, Inc. and UnitedHealthcare Insurance Company reported the highest absolute increase in number of adverse decisions (5,221 and 3,495, respectively).

2. The carriers administratively reversed only 258 of the reported adverse decisions, 66% less than they administratively reversed in FY 2015.

3. In FY 2016, consumers filed 6,219 grievances, an increase over the 5,282 grievances filed in FY 2015. This increase continues the upward trend in number of grievances filed in prior reporting years.

4. The largest percentage of grievances filed were in the dental (23%), lab/radiology (25%), pharmacy (26%) and physician (14%) service categories.

5. Overall, during the internal grievance process carriers altered their original adverse decisions in 54% of the grievances reported in FY 2016. Carriers overturned their adverse decisions in 50% of the grievances and modified their determinations in 4% of the grievances filed. This represents an increase in the percentage of grievances carriers altered since FY 2015, when carriers reported changing 50% of their adverse decisions.

6. Adverse decisions involving mental health/substance abuse services continue to be overturned or modified less than 50% of the time. In FY 2016, carriers reported an overturned or modified rate of only 19% for mental health and substance abuse services. This continues years of low reversal rates: 42% in FY 2015, 31% in FY 2014, 27% in FY 2013 and 23% in FY 2012.

7. Adverse decisions involving pharmacy services are the most likely to be overturned as reflected in a five year review of data; 72% in FY 2012, 74% in FY 2013, 79% in FY 2014, 62% in FY 2015, and 71% in FY 2016.

V. Maryland Insurance Administration (MIA)

The MIA has regulatory oversight of insurance products offered in Maryland. In 1998, the Appeals and Grievances Law was enacted by the General Assembly to provide a fair process for resolving disputes regarding the medical necessity of a proposed or delivered health care service (See Title 15, Subtitle 10A of the Insurance Article). Until July 1, 2011, the Appeals and Grievances law applied only to individuals with insured health benefits. However, because of the ACA expansion of external appeal rights, effective July 1, 2011, the Department of Budget and Management for the State of Maryland and, effective June 28, 2013, Cecil County Public Schools voluntarily elected to use the Maryland Insurance Administration's external review process to provide external review for their self-funded employee health benefit plans.[8]

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

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then the MIA will prepare the case for review. As part of the preparation, the MIA will contact the complainant and the carrier in writing, giving them a deadline for submitting additional documentation to be considered in the review as applicable. Once the MIA receives the proper documentation, the case is copied and forwarded to an Independent Review Organization for medical necessity reviews. In selecting an IRO, the MIA ensures that the IRO has an appropriate board-certified physician available to review the case. Upon receipt of the case from the MIA, the IRO then transmits the case to its expert reviewer who researches and reviews the case, renders an opinion, and transmits the opinion back to the IRO. The IRO, in turn, conducts a quality review of the expert reviewer's opinion. For medical necessity reviews, the MIA asks the IRO to respond to specific questions as set forth in a cover letter attached to the complaint.

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

The IRO will orally inform the MIA of the expert reviewer's determination and follow up with the written determination via facsimile and first class mail. If the IRO reviewer's recommendation is to overturn, uphold or modify the carrier's denial, the MIA may accept this recommendation and base its final closing letter on the professional judgment of the IRO reviewer. The complainant is notified of the outcome by telephone, mail, or both. The MIA also forwards a copy of the IRO's medical opinion and invoice to the carrier via facsimile and U.S. mail. In all instances, the carrier that is the subject of the complaint must pay the expenses of the IRO selected by the MIA. Hearing rights to contest the MIA decision are given to all consumers, with the exception of individuals covered under the State of Maryland employee/retiree plan.

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

MIA Statistics FY 2016

MIA-provided data are reported on the charts and tables contained on pages 22-29 of this report. The data reflect only those cases where a disposition has been rendered; pending cases are not reported.

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

1. The MIA's Appeals and Grievances Unit received 28% more complaints in FY 2016 over FY 2015. 1,120 complaints were received in FY 2016. After reviewing these complaints, the MIA determined that 536 involved MIA-regulated adverse decisions.

2. The MIA referred 87 complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 449 complaints in which complainants challenged the carrier's grievance decision, a 28% increase over the number of complaints investigated in FY 2015. The MIA modified or reversed the carrier's grievance decision or the carrier reversed its own grievance decision during the course of the MIA's investigation in 298 cases (66%). Conversely, the MIA upheld 151 (34%) of the carrier decisions.

4. Similar to FY 2015, the largest percentages of grievances filed were in the pharmacy (37%), experimental (14%), dental care (13%), and physician services (11%) categories. There was a notable increase in the pharmacy category over the 22% of grievances filed in FY 2015.

VI. Health Education and Advocacy Unit (HEAU)

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

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

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

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

HEAU Statistics FY 2016

The HEAU Appeals and Grievances data[9] are reported in the charts and tables contained on pages 30-47 of this report. The data reflect medical necessity, contractual, and eligibility denials. Because newly filed cases contain incomplete data, this report includes only those cases the HEAU closed during FY 2016.

The HEAU closed 2,343 cases in FY 2016.

1. 54% of the complaints closed by the HEAU involved "carriers" defined in this report to include insurers, nonprofit health service plans, HMOs, dental plan organizations, third-party administrators, utilization review agents, pharmaceutical benefit management companies, and any other person that provides health benefit plans.

2. 13% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection related issues.

3. 947 of the complaints closed by the HEAU were appeals and grievances related cases. Not all of the 947 appeals and grievances complaints filed with the HEAU were mediated. Some consumers, or other persons, file complaints but an authorization to release medical records form, or authorized representative form (for Maryland Health Connection cases), which the HEAU requires to mediate the case, is never completed. Other complaints are filed for the record only or are referred to another more appropriate agency. Of the 947 appeals and grievances cases the HEAU closed during FY 2016, 623 or 66% involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 623 cases involved more than one carrier.

4. Of the 623 appeals and grievances cases the HEAU mediated during FY 2016, 30% were adverse decision (*medical necessity*) cases, 58% were coverage decision (*contractual exclusion*) cases, and 12% were eligibility denials.

5. The HEAU mediation process resulted in carriers overturning or modifying 55% of the appeals and grievances cases. The carriers overturned or modified 57% of the medical necessity cases, 49% of the coverage decision cases, and 81% of the eligibility denial cases.

6. HEAU mediation efforts resulted in carriers changing their decisions 71% of the time in cases involving at least one MIA-regulated plan. For cases involving non-regulated plans, the HEAU efforts resulted in carriers changing their decisions 41% of the time.

7. In FY 2016, the HEAU assisted patients in recovering or saving more than $2.7 million dollars, including over $2.1 million in appeals and grievances cases.

[9] Detailed data related to the outcomes of cases handled by the HEAU unrelated to the Appeals and Grievances Law are not contained in this report; some general complaint numbers and categories are reported for informational purposes.

VII. Successes and Areas of Concern

Maryland's Appeals and Grievances Law and the assistance provided by the HEAU continue to provide significant benefits to consumers. As the report reflects, 55% of the carrier denials are overturned or modified when challenged by the HEAU. While this number reflects positive results for consumers who reach out to the HEAU, it highlights the fact that carriers are inappropriately denying claims, causing consumers significant financial and emotional burden. During FY 2016, the HEAU addressed many marketplace concerns, *inter alia*, financially devastating air ambulance bills, health insurance rate review, balance billing, mental health parity, network adequacy standards, medical records costs, HIPAA violations and rights for consumers under HIPAA, consumer protections on the State's Health Information Exchange, advanced directives, wellness program issues, etc. The HEAU also addressed the following marketplace concerns.

A. Proof of Loss

The HEAU received complaints from consumers who were denied coverage under their health plans for out-of-network services because of late claim submission. The plans at issue included language that required consumers to submit their proof of loss within 90 days after the date of loss. Most consumers were unaware of this strict claim filing deadline having had longer deadlines in the past. Proof of loss timeliness requirements enable carriers to fully investigate claims and prevent prejudice due to delay, but a 90 day time limit is onerous to the consumer and a longer time period does not result in any prejudice to the carrier. In fact, providers, who are staffed, are given 180 days from the date of service to submit a claim for reimbursement. The HEAU sought a legislative solution for consumers and the General Assembly enacted Chapter 445, the Consumer Health Claim Filing Fairness Act, to allow consumers at least 1 year to submit a claim.

B. Termination of Exchange-based Plans

In February 2016, thousands of Maryland Health Connection-related health plans were cancelled for non-payment of premiums. The HEAU received hundreds of calls and dozens of written complaints from terminated consumers. There were several different categories of reasons for the terminations: timely payments posted late; underpayment of full premiums; lack of premium notice leading to a failure to pay; carrier cancellation of auto-payments; and a failure to provide the required 90-day grace period for consumers receiving subsidies. The HEAU received complaints from consumers who were terminated because they accidentally or by technical error underpaid their premiums; one consumer was $10 short because of a "mathematical error" and the MIA received a complaint about a $.01 underpayment. We received complaints from consumers who asserted that they paid their 2015 premium amounts for their 2016 plans because they did not receive new invoices showing their increase in premiums for the 2016 plan year. We heard from others who did not pay because they did not receive invoices. Some consumers were terminated because the auto-pay they had established with their carrier was discontinued for the 2016 plan year. The majority of complaining consumers were receiving subsidies and still within their 90-day grace period, but were terminated because carriers asserted that the grace period did not apply to the first premium of the new plan year.

In all instances, the carrier termination letters directed consumers to the Maryland Health Connection for reinstatement, but representatives at Maryland Health Connection told consumers that the carriers had to institute the reinstatement. It was a consistent theme among cases brought to the HEAU that Maryland Health Connection and the carriers directed responsibility at each other. The HEAU intervened in these cases and worked with all stakeholders to reinstate policies where appropriate. In one case, the HEAU obtained reinstatement for a consumer whose life-saving organ transplant was going to be cancelled because of an improper termination. The HEAU will continue to advocate for consumers on a case-by-case basis and systemically as the marketplace continues to evolve.

One notable outstanding issue also relates to plan terminations. The HEAU received numerous complaints from consumers who were unable to terminate their Maryland Health Connection-related health plans. Again, Maryland Health Connection and the carriers directed responsibility at each other. While it is clear that some plan terminations – those of single individuals on a family policy receiving subsidies – present technical challenges for Maryland Health Connection and the carriers, it is also clear that consumers must be able to simply and easily terminate coverage without undue delay and they must know how to do so without being pointed in multiple, inconsistent directions. The HEAU has been advocating these consumer protection principles during regulation drafting meetings with Maryland Health Connection and on a case-by-case basis.

C. Prescription Drug Pricing and Coverage

In FY 2016, the largest percentage of grievances issued by carriers were in the pharmacy category (26%); 13% percent of the Appeals and Grievances cases mediated and closed by the HEAU were pharmacy-related, including claims related to high cost; and the largest number of grievances filed with the MIA were pharmacy-related (37%). It is clear from this report and highly publicized incidents of increasing drug costs and price gouging, that drug pricing and coverage issues are worthy of legislative attention.

D. Outpatient Facility Fees

The HEAU has received an increasing number of complaints from consumers being billed for outpatient facility fees by medical practices that have been acquired by hospital systems. Consumers complain they are receiving the same services after acquisition as they received before acquisition, but are being charged a facility fee that provides them no value. Lack of notice about the outpatient facility fee is a chronic complaint; consumers say they would not have made the appointment if they had been told about the fee when making the appointment. The amounts of the fees seem to be increasing, e.g., $800 was the fee charged to a consumer whose retiring psychiatrist made an appointment for her with a new psychiatrist, in a regulated space, who simply prescribed the same medications she had been on for many years. Consumers see these fees as unjustifiable and burdensome because most plans now have high deductibles. The HEAU has expressed its concerns about outpatient facility fees to the Health Services Cost Review Commission (HSCRC) and the Maryland Hospital Association and is advocating for remedial relief in ongoing discussions about emerging value-based payment systems.

E. Maryland's Transition from Fee-for-Service to Value-based Payment Arrangements

During the 2016 Interim, the HEAU has participated in workgroups addressing statutory changes that some stakeholders are seeking as Maryland transitions from fee-for-service to value-based payment arrangements. The HEAU is concerned that essential consumer protections, such as those in the Maryland Patient Referral Law (MPRL), which limits the ability of providers to refer patients to other providers or entities in which they have a financial interest, may be reduced or eliminated without providing consumers new equivalent protections.

VII. Conclusion

Maryland continues to be a leader and innovator in the health care marketplace. As the marketplace continues to rapidly and significantly evolve we must continue to remain aware of possible barriers to consumers receiving coverage and care. The HEAU will continue to be the voice of and advocate for the ultimate beneficiaries of the marketplace – the patients.

Appendix

Carrier Cases
Adverse Decisions, Grievances and Outcomes

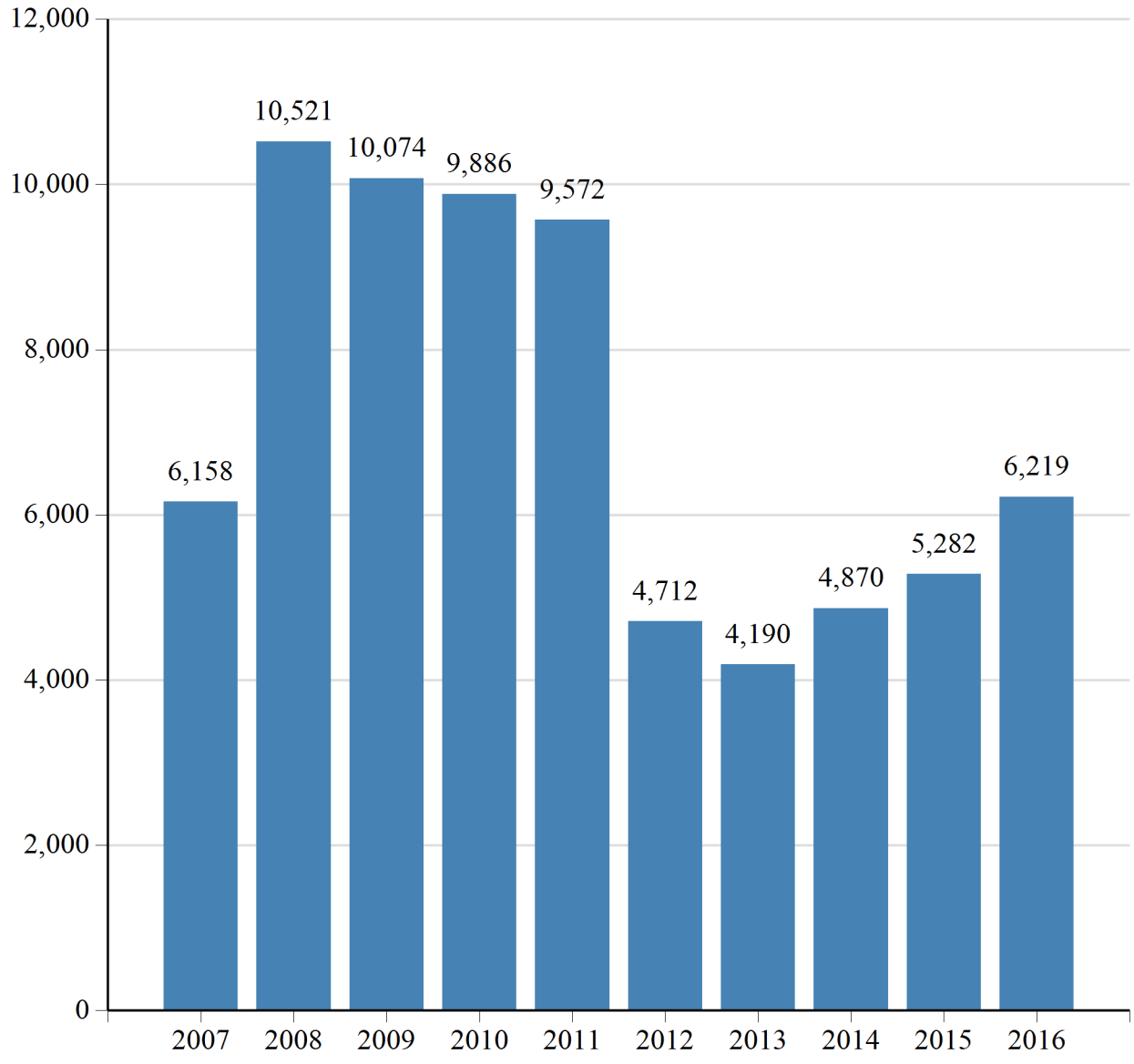
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Aetna Dental Inc.	538	0	1	0%	100%
Aetna Health Inc. (a Pennsylvania corporation)	245	15	225	62%	38%
Aetna Life Insurance Company	369	32	188	70%	30%
All Savers Insurance Company	171	0	21	48%	52%
Ameritas Life Insurance Corp.	524	0	44	36%	64%
CareFirst BlueChoice, Inc.	8,972	0	1,105	40%	60%
Carefirst of Maryland, Inc.	9,726	0	387	32%	68%
CIGNA Dental Health of Maryland, Inc.	94	0	0	0%	0%
CIGNA Health and Life Insurance Company	5,628	71	657	49%	51%
Connecticut General Life Insurance Company	30	0	5	60%	40%
Coventry Health and Life Insurance Company	142	0	61	52%	48%
Coventry Health Care of Delaware, Inc.	92	1	81	54%	46%
Delta Dental Insurance Company	3	0	0	0%	0%
Delta Dental of Pennsylvania	24	0	0	0%	0%
Dental Benefit Providers of Illinois, Inc.	510	0	91	34%	66%
DentaQuest Mid-Atlantic, Inc.	536	0	11	64%	36%
Dominion Dental Services, Inc.	197	0	24	21%	79%
Dominion USA, Inc.	576	0	16	63%	38%
Evergreen Health Cooperative Inc.	1,881	51	433	46%	54%
Golden Rule Insurance Company	12	0	0	0%	0%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Group Dental Service of Maryland, Inc.	4,473	6	11	64%	36%
Group Hospitalization and Medical Services, Inc.	7,607	0	551	45%	55%
Guarantee Trust Life Insurance Company	0	0	1	100%	0%
Guardian Life Insurance Company of America	1,211	0	598	49%	51%
HumanaDental Insurance Company	250	0	10	10%	90%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	694	1	38	58%	42%
Kaiser Permanente Insurance Company	50	0	7	57%	43%
Lincoln Life & Annuity Company of New York	3	0	1	0%	100%
Lincoln National Life Insurance Company	149	48	30	40%	60%
MAMSI Life and Health Insurance Company	365	0	69	55%	45%
Metropolitan Life Insurance Company	206	33	20	45%	55%
Optimum Choice, Inc.	1,649	0	176	39%	61%
Principal Life Insurance Company	126	0	33	61%	39%
Reliance Standard Life Insurance Company	88	0	5	40%	60%
Standard Insurance Company	34	0	7	57%	43%
Standard Security Life Insurance Company of New York	0	0	77	81%	19%
State Farm Mutual Automobile Insurance Company	0	0	3	67%	33%
Sun Life Assurance Company of Canada	69	0	21	52%	48%
Time Insurance Company	2	0	1	0%	100%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Unicare Life & Health Insurance Company	2	0	0	0%	0%
Union Security Insurance Company	641	0	34	41%	59%
United Concordia Dental Plans, Inc.	0	0	2	100%	0%
United Concordia Life and Health Insurance Company	841	0	188	57%	43%
United States Life Insurance Company In the City of New York	1	0	1	100%	0%
UnitedHealthcare Insurance Company	5,436	0	886	43%	57%
UnitedHealthcare of the Mid-Atlantic, Inc.	555	0	99	38%	62%
Totals	**54,722**	**258**	**6,219**	**46%**	**54%**

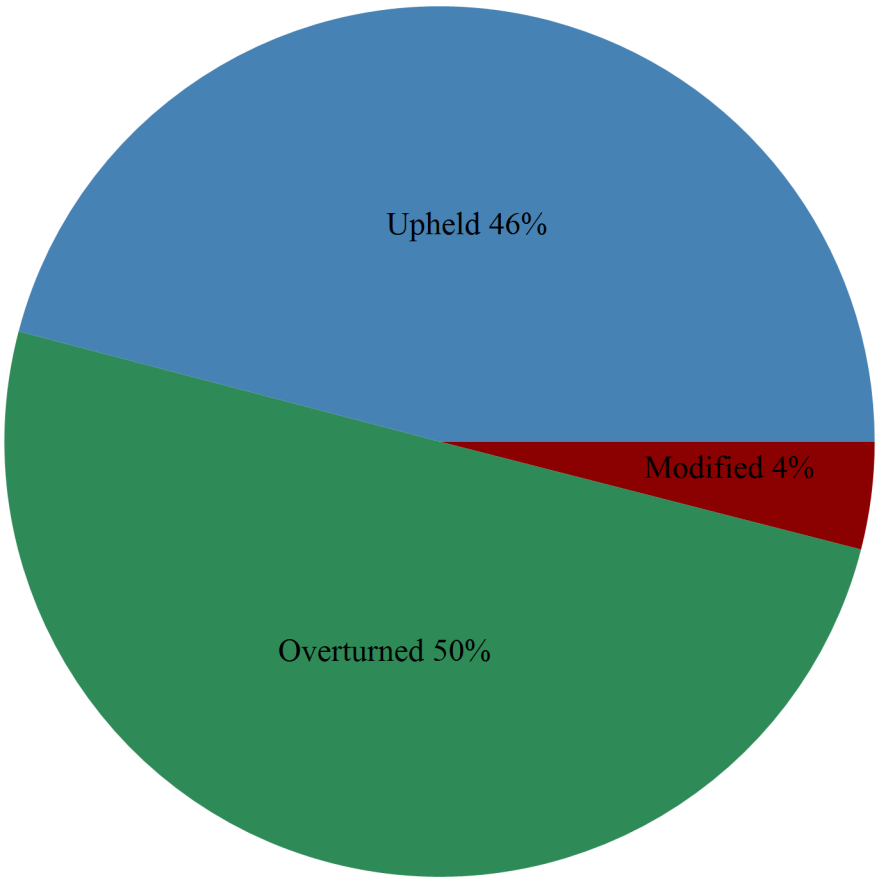
Carrier Grievances Cases
Number of Grievances Since Fiscal Year 2007

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



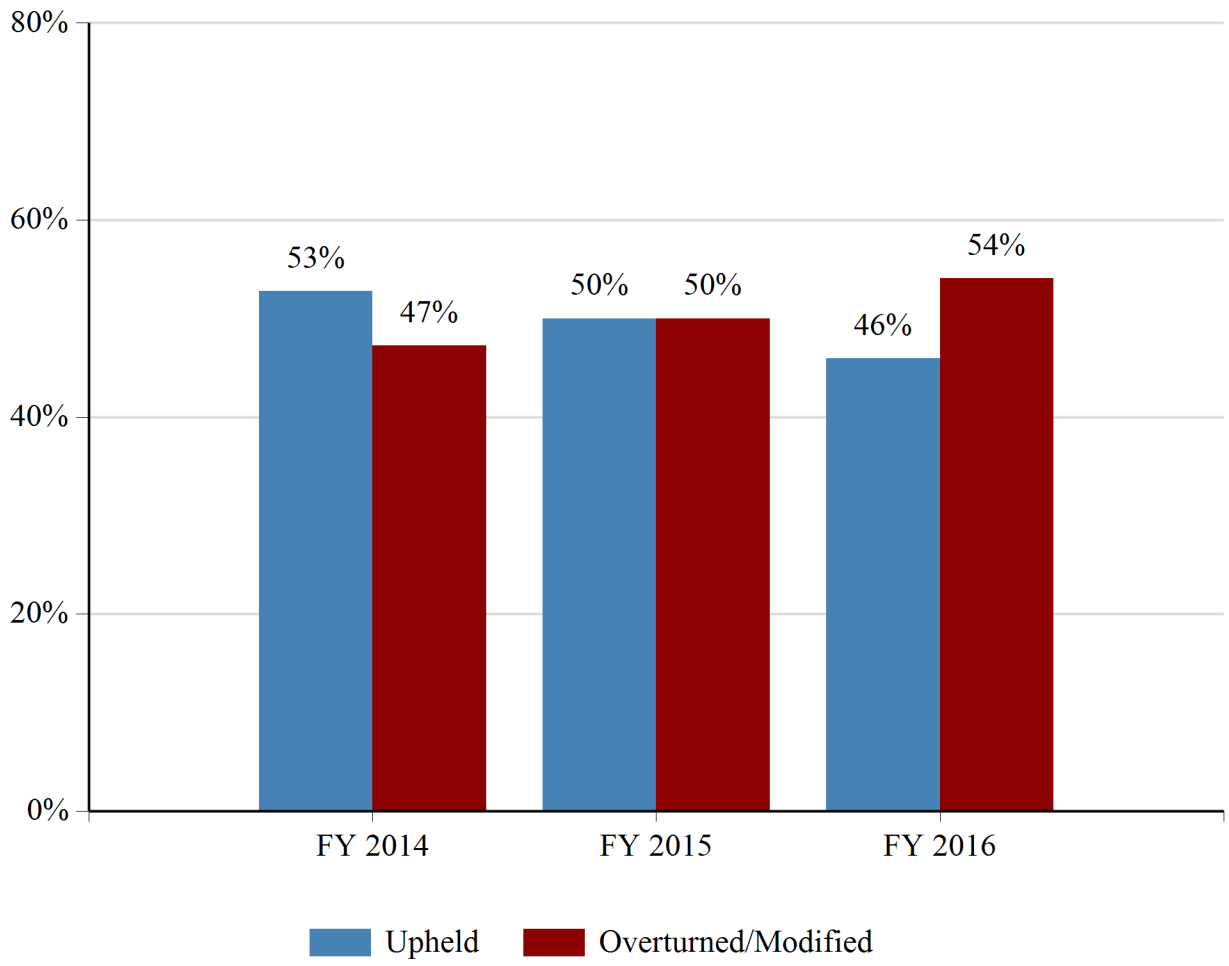
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 6,219 internal grievances filed with carriers in FY 2016, as reported by the carriers.



Carrier Grievances Cases
Three Year Comparison of Outcomes

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



Carrier Grievances Cases
Types of Services

Carriers must report the types of services involved in the adverse decisions they issue and the internal grievances they receive. The table below details the types of services involved in the adverse decisions issued and internal grievances filed in FY 2016, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	16,853	30.797%	1,458	23.444%
Durable Medical Equipment	1,591	2.907%	145	2.332%
Emergency Room	429	0.784%	33	0.531%
Home Health	378	0.691%	7	0.113%
Inpatient Hospital	1,202	2.197%	166	2.669%
Laboratory, Radiology	14,926	27.276%	1,584	25.470%
Mental Health / Substance Abuse	1,967	3.595%	122	1.962%
Other*	599	1.095%	100	1.608%
Pharmacy	8,053	14.716%	1,610	25.888%
Physician	6,967	12.732%	901	14.488%
PT, OT, ST, including inpatient rehabilitation	1,710	3.125%	81	1.302%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	47	0.086%	12	0.193%
Totals	**54,722**	**100%**	**6,219**	**100%**

*"Other" means obesity, IVF, podiatry, hearing and vision.

Carrier Grievances Cases
Outcomes by Service Type

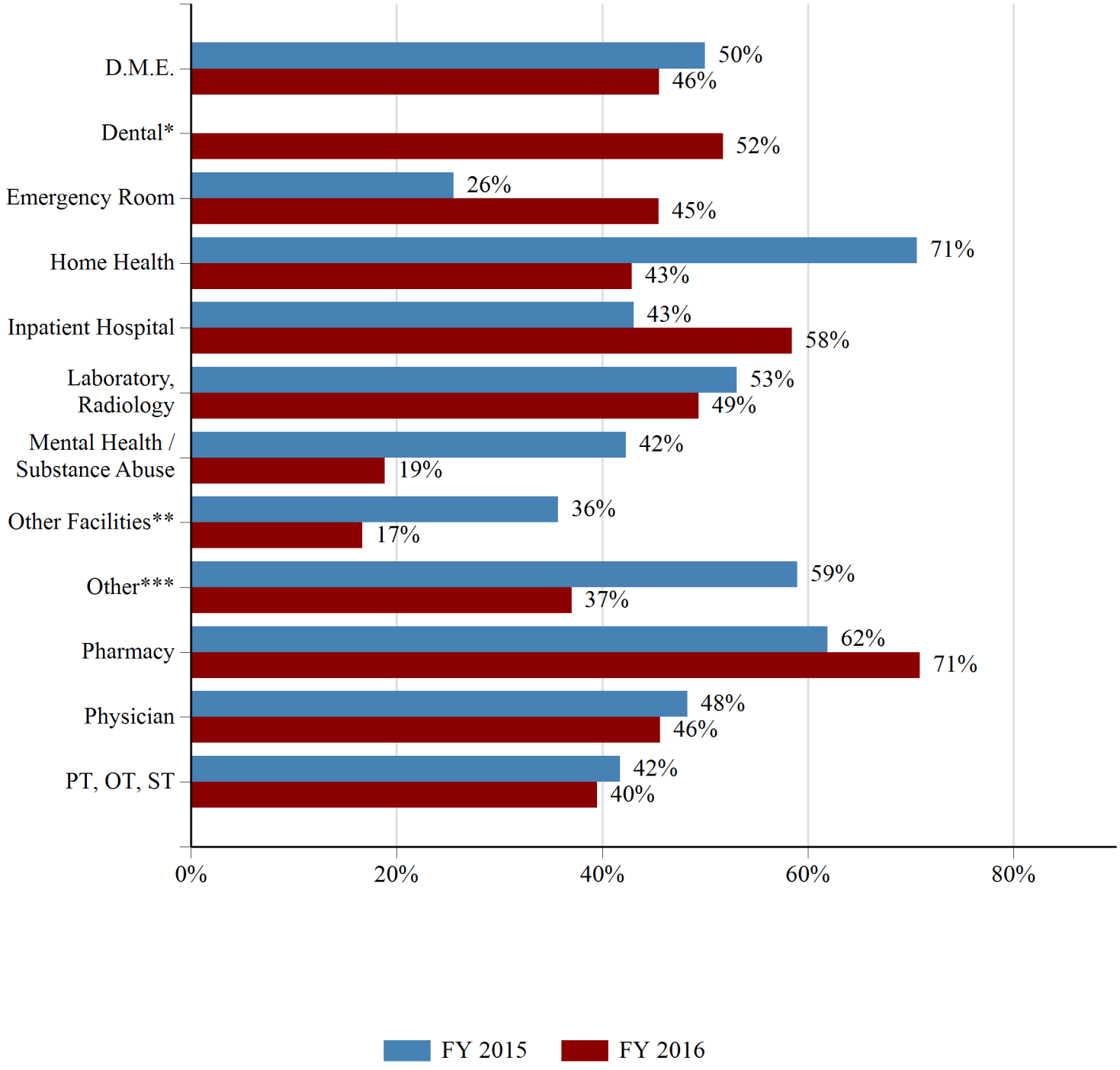
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Dental	1,458	48%	52%
Durable Medical Equipment	145	54%	46%
Emergency Room	33	55%	45%
Home Health	7	57%	43%
Inpatient Hospital	166	42%	58%
Laboratory, Radiology	1,584	51%	49%
Mental Health / Substance Abuse	122	81%	19%
Other*	100	63%	37%
Pharmacy	1,610	29%	71%
Physician	901	54%	46%
PT, OT, ST, including inpatient rehabilitation	81	60%	40%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	12	83%	17%
Totals	**6,219**	**46%**	**54%**

*"Other" means obesity, IVF, podiatry, hearing and vision.

Carrier Grievances Cases
Two Year Comparison by Service Type

The chart below compares the percentages of grievances carriers overturned or modified by types of services, comparing FY 2015 and FY 2016.

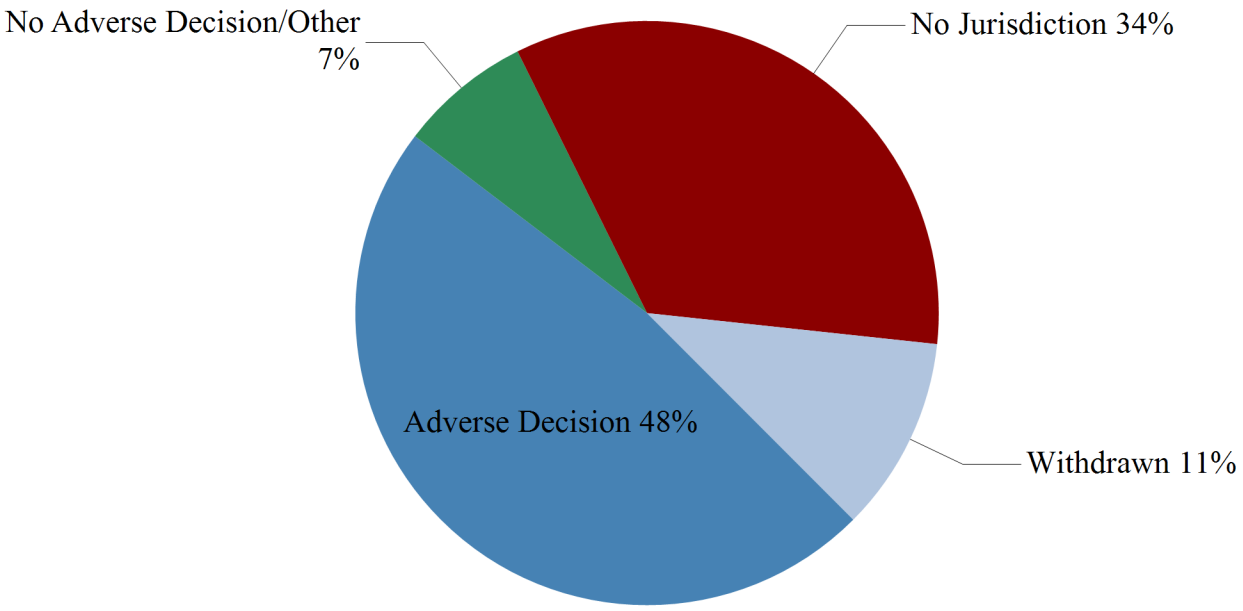


* The service type categories changed in calendar year 2015. Dental was previously in a grouped category.
** "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.
*** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints
Initial Review of Cases

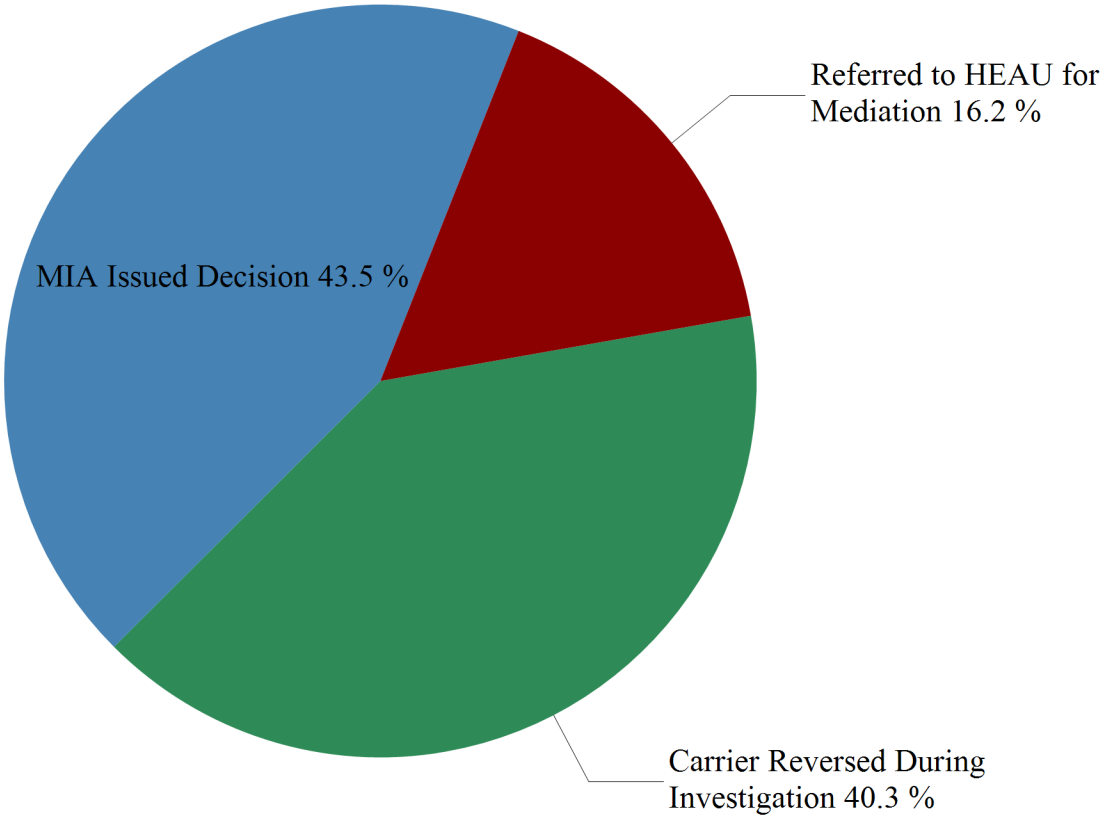
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some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

The chart below details the initial disposition of the 1,120 cases filed with the MIA's Appeals and Grievances Unit during FY 2016.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2016, the MIA determined that 536 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 87 cases to the HEAU where the patient had not exhausted the carrier's internal grievance process. The remaining cases resulted in the carriers reversing their decisions or the MIA issuing a decision. The chart below details the initial disposition of the 536 grievances the MIA reviewed during FY 2016.



MIA Appeals and Grievances Cases
Carriers and Disposition

The table below details the outcomes of the 449 grievances complaints the MIA investigated during FY 2016. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

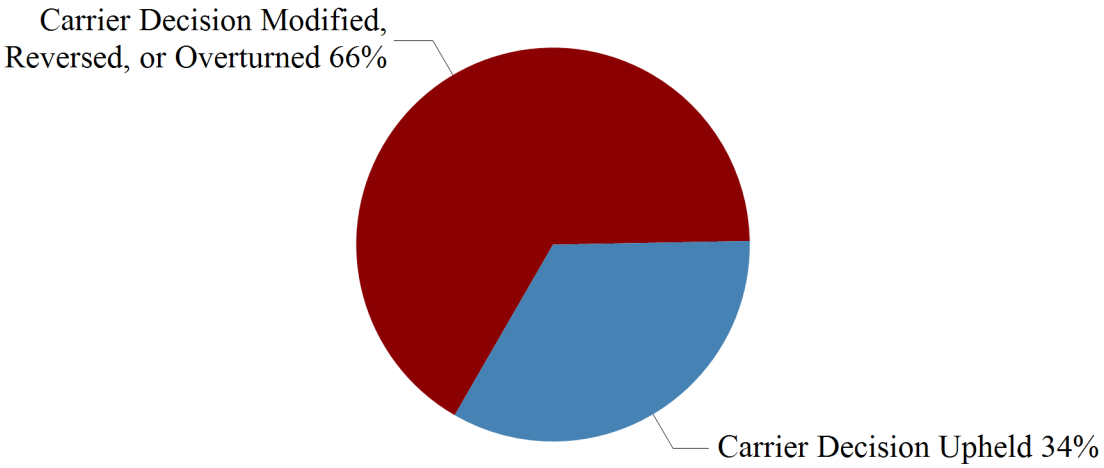
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	4	1	25.0%	0	0.0%	0	0.0%	3	75.0%
Aetna Health Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Aetna Life Insurance Company	14	8	57.1%	3	21.4%	0	0.0%	3	21.4%
All Savers Insurance Company	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
Ameritas Life Insurance Corp.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
CareFirst BlueChoice, Inc.	92	30	32.6%	18	19.6%	1	1.1%	43	46.7%
Carefirst of Maryland, Inc.	81	30	37.0%	14	17.3%	2	2.5%	35	43.2%
CIGNA Health and Life Insurance Company	23	7	30.4%	8	34.8%	2	8.7%	6	26.1%
Coventry Health and Life Insurance Company	2	2	100.0%	0	0.0%	0	0.0%	0	0.0%
Coventry Health Care of Delaware, Inc.	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
Delta Dental of Pennsylvania	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
DentaQuest Mid-Atlantic, Inc.	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Dominion Dental Services, Inc.	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Evergreen Health Cooperative Inc.	12	4	33.3%	0	0.0%	0	0.0%	8	66.7%
Express Scripts Insurance Company	2	0	0.0%	2	100.0%	0	0.0%	0	0.0%
Express Scripts, Inc.	10	4	40.0%	2	20.0%	0	0.0%	4	40.0%

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Golden Rule Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Group Dental Service of Maryland, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Group Hospitalization and Medical Services, Inc.	25	12	48.0%	5	20.0%	0	0.0%	8	32.0%
Guardian Life Insurance Company of America	9	6	66.7%	1	11.1%	0	0.0%	2	22.2%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	6	3	50.0%	0	0.0%	0	0.0%	3	50.0%
MAMSI Life and Health Insurance Company	6	2	33.3%	1	16.7%	0	0.0%	3	50.0%
Metropolitan Life Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Optimum Choice, Inc.	19	5	26.3%	1	5.3%	0	0.0%	13	68.4%
Principal Life Insurance Company	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
Standard Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Union Security Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
United Concordia Life and Health Insurance Company	14	5	35.7%	5	35.7%	1	7.1%	3	21.4%
UnitedHealthcare Insurance Company	87	21	24.1%	11	12.6%	2	2.3%	53	60.9%
UnitedHealthcare Life Insurance Company	1	0	0.0%	1	100.0%	0	0.0%	0	0.0%
UnitedHealthcare of the Mid-Atlantic, Inc.	18	3	16.7%	0	0.0%	0	0.0%	15	83.3%
UnitedHealthcare Services, Inc.	7	2	28.6%	2	28.6%	0	0.0%	3	42.9%
Totals	**449**	**151**	**33.6%**	**74**	**16.5%**	**8**	**1.8%**	**216**	**48.1%**

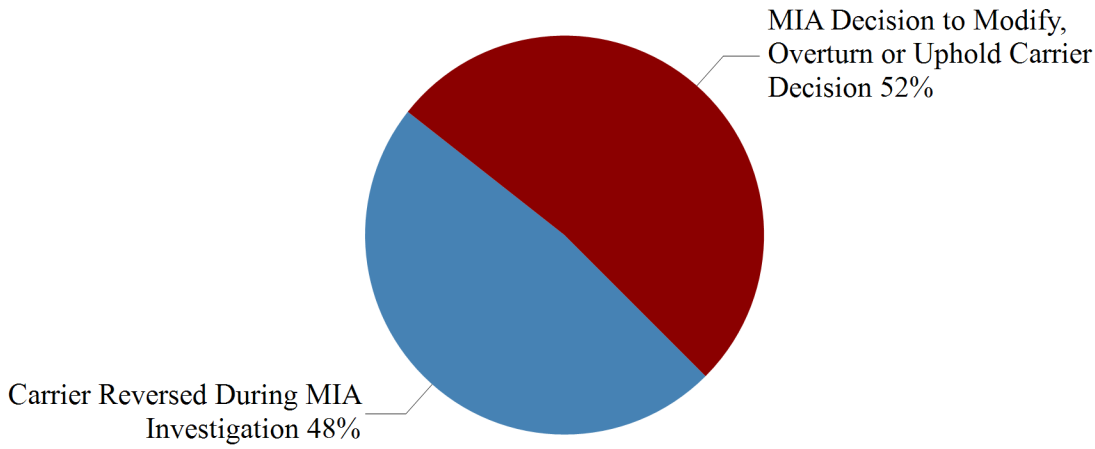
Percentages may not equal 100% due to rounding.

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 449 grievances the MIA investigated during FY 2016.

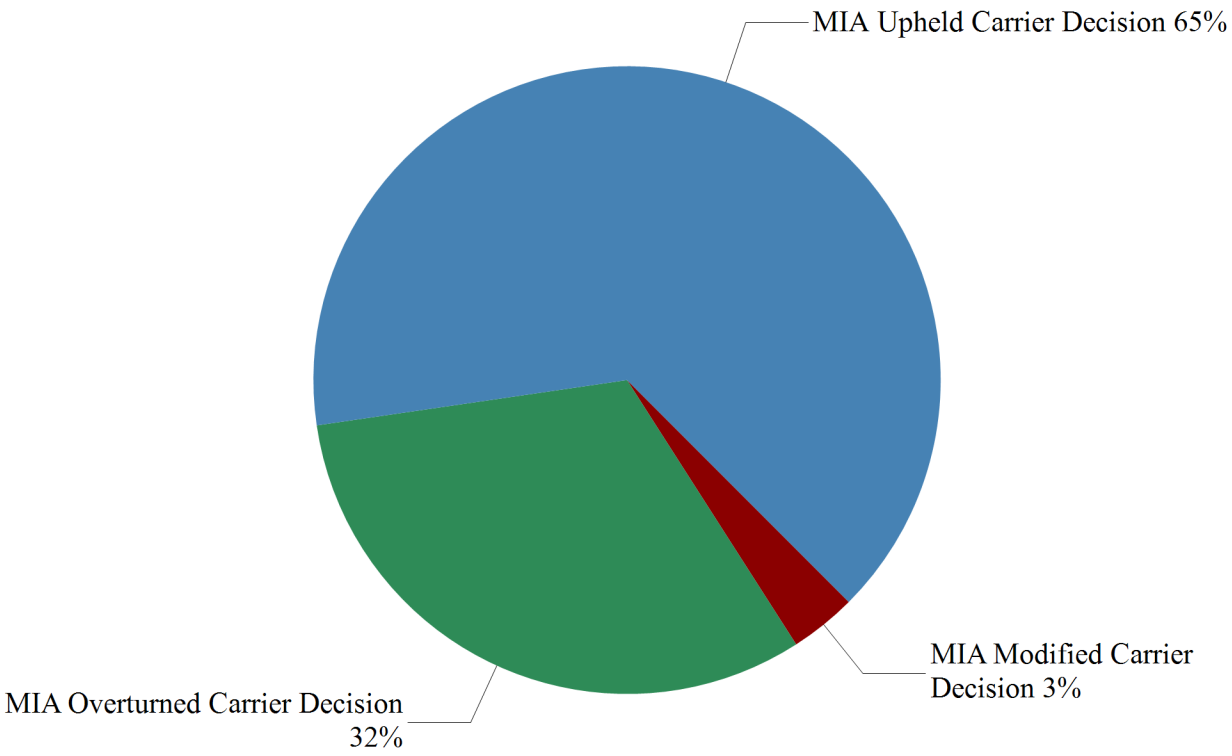


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 233 cases the MIA forwarded to an IRO for review in FY 2016.



MIA Appeals and Grievances Cases
Types of Services Denied and Outcomes

The table below identifies the types of services involved in grievances the MIA investigated during FY 2016. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

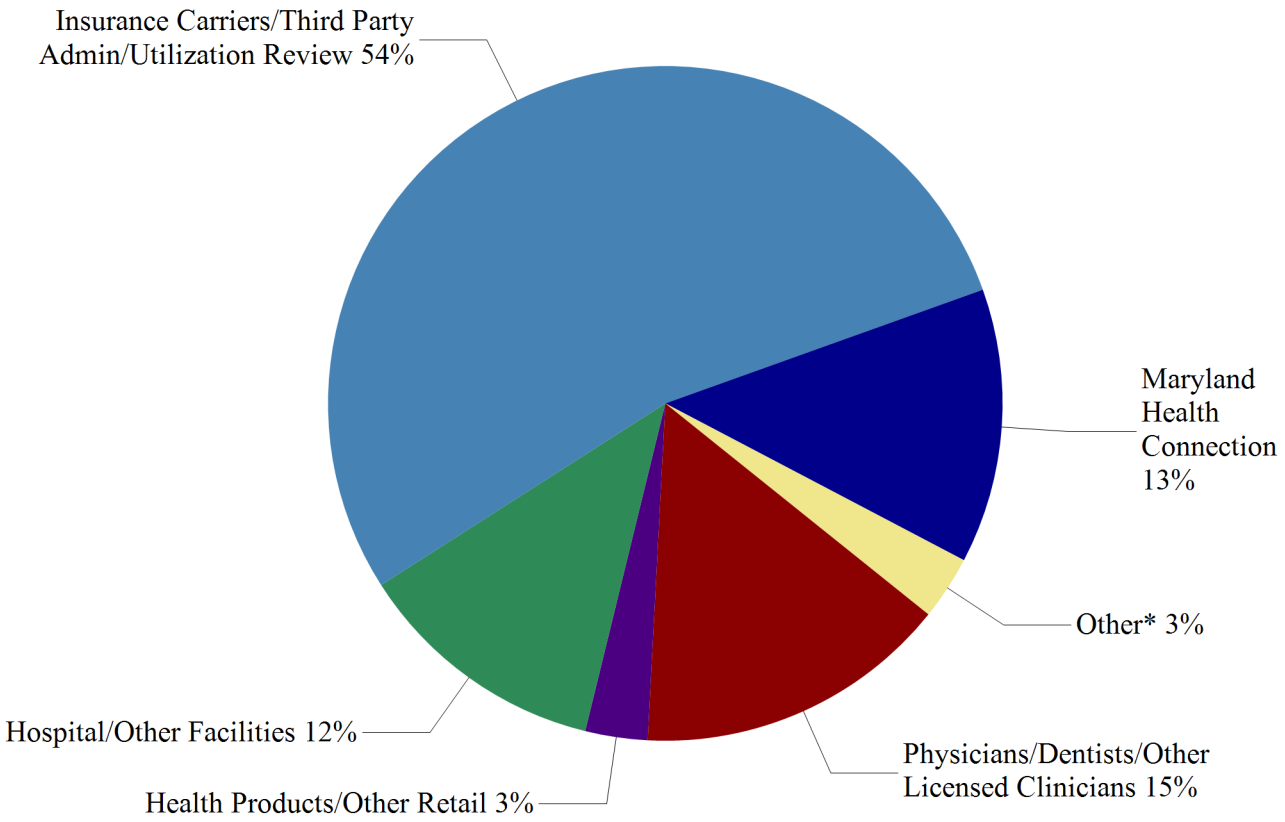
Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Air Ambulance	2	0%	1	50%	0	0%	0	0%	1	50%
Cosmetic	4	1%	3	75%	1	25%	0	0%	0	0%
Denial of Hospital Days	13	3%	5	38%	2	15%	0	0%	6	46%
Dental Care Services	60	13%	23	38%	10	17%	3	5%	24	40%
Durable Medical Equipment	14	3%	3	21%	3	21%	0	0%	8	57%
Emergency Room Denial	2	0%	1	50%	0	0%	0	0%	1	50%
Emergency Treatment Denial	4	1%	1	25%	0	0%	0	0%	3	75%
Experimental	63	14%	39	62%	19	30%	1	2%	4	6%
Habilitative Service	3	1%	0	0%	0	0%	0	0%	3	100%
Harvoni	8	2%	2	25%	3	38%	0	0%	3	38%
In-Patient Rehabilitation Services	2	0%	0	0%	2	100%	0	0%	0	0%
Lab, Imaging, Test Services	22	5%	6	27%	4	18%	1	5%	11	50%
Mental Health Partial Hospitalization	3	1%	2	67%	1	33%	0	0%	0	0%
Mental Health/Substance Abuse (Inpatient) Services	7	2%	5	71%	1	14%	0	0%	1	14%
Mental Health/Substance Abuse (Outpatient) Services	11	2%	4	36%	0	0%	0	0%	7	64%
Out-of-Network Benefits	2	0%	2	100%	0	0%	0	0%	0	0%
PCP Referrals	1	0%	1	100%	0	0%	0	0%	0	0%
Pharmacy Benefits	2	0%	1	50%	1	50%	0	0%	0	0%
Pharmacy Services/Formulary Issues	166	37%	32	19%	19	11%	2	1%	113	68%
Physician Services	50	11%	17	34%	8	16%	1	2%	24	48%

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
PT, OT, ST Services	7	2%	2	29%	0	0%	0	0%	5	71%
Skilled Nursing Facility Care Services	2	0%	1	50%	0	0%	0	0%	1	50%
Transportation Services	1	0%	0	0%	0	0%	0	0%	1	100%
Totals	**449**	**100.0%**	**151**	**33.6%**	**74**	**16.5%**	**8**	**1.8%**	**216**	**48.1%**

Percentages may not equal 100% due to rounding.

HEAU Cases
Subject of Complaints

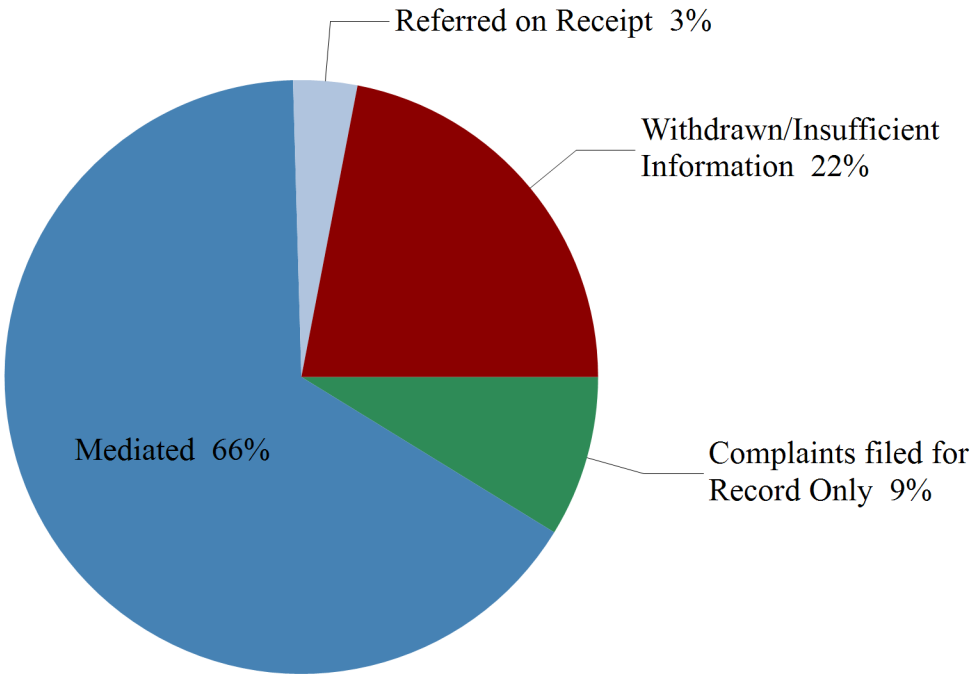
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, and various other issues encountered in the health care marketplace. The HEAU also assisted consumers who experienced enrollment difficulties on Maryland Health Connection. The chart below illustrates the types of industries involved in the cases the HEAU closed during FY 2016. The HEAU closed 2,343 complaints. Some complaints were filed against more than one industry.



* "Other" includes Collection/Billing Entities (1.6%), Government Agency (.4%), Ambulance (.5%), and other non-specific categories (e.g. Telemarketing).

HEAU Appeals and Grievances Cases
Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Some consumers, or other persons, file complaints but never complete an authorization to release medical records, a form required by the HEAU to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. The chart below details the initial disposition of the 947 Appeals and Grievances cases closed by the HEAU during FY 2016.



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

The table below identifies the names of the carriers and the outcomes of the Appeals and Grievances cases mediated and closed by the HEAU during FY 2016. Some complaints involved more than one carrier; there were 666 carriers involved in the 623 cases the HEAU mediated and closed in FY 2016. Maryland Health Connection is listed as a carrier in cases where the appeal or grievance involved a dispute that required both the carrier and Maryland Health Connection to act to resolve the dispute.

Carrier	Total Cases	Upheld		Overturned/Modified	
AARP Dental Insurance Plan					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Aetna					
State Regulated	19	6	32%	13	68%
Not State Regulated	46	35	76%	11	24%
Total Complaints	**65**	**41**	**63%**	**24**	**37%**
AIG					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Anthem Blue Cross Blue Shield					
Not State Regulated	15	7	47%	8	53%
Total Complaints	**15**	**7**	**47%**	**8**	**53%**
Anthem UM Services, Inc.					
Not State Regulated	6	2	33%	4	67%
Total Complaints	**6**	**2**	**33%**	**4**	**67%**
APWU Health Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Associated Administrators					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Assurant Health					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Assurant Employee Benefits					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield Federal Employee Program					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield of Illinois					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Blue Cross Blue Shield of Massachusetts					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Capital Blue Cross					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
CareFirst					
State Regulated	158	44	28%	114	72%
Not State Regulated	61	38	62%	23	38%
Total Complaints	**219**	**82**	**37%**	**137**	**63%**
CareFirst Administrators					
Not State Regulated	6	4	67%	2	33%
Total Complaints	**6**	**4**	**67%**	**2**	**33%**
CareFirst the Dental Network					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
CIGNA					
State Regulated	9	3	33%	6	67%
Not State Regulated	41	19	46%	22	54%
Total Complaints	**50**	**22**	**44%**	**28**	**56%**

Carrier	Total Cases	Upheld		Overturned/Modified	
CIGNA Dental					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CoreSource					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Coventry Health Care					
State Regulated	2	1	50%	1	50%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**3**	**1**	**33%**	**2**	**67%**
CVS Caremark					
State Regulated	9	3	33%	6	67%
Not State Regulated	17	9	53%	8	47%
Total Complaints	**26**	**12**	**46%**	**14**	**54%**
Davis Vision					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Delta Dental					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Delta Dental of North Carolina					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Delta Dental of Pennsylvania					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Denex Dental					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Denta Quest Mid Atlantic, Inc.					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Electrical Welfare Trust Fund					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Empire Blue Cross Blue Shield					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Evergreen Health Cooperative, Inc.					
State Regulated	8	2	25%	6	75%
Total Complaints	**8**	**2**	**25%**	**6**	**75%**
Express Scripts					
State Regulated	3	0	0%	3	100%
Not State Regulated	4	2	50%	2	50%
Total Complaints	**7**	**2**	**29%**	**5**	**71%**
EyeMed Vision Care					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
FCE Benefits Administrators					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Golden Rule Insurance					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Government Employees Health Association (GEHA)					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Group Dental Service of Maryland, Inc.					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Guardian Life insurance Company of America					
State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
HCC Medical Insurance Services, LLC					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Horizon BlueCross BlueShield of New Jersey					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	8	3	37.5%	5	62.5%
Not State Regulated	4	3	75%	1	25%
Total Complaints	**12**	**6**	**50%**	**6**	**50%**
Key Benefit Administrators					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Mail Handlers Benefit Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Maryland Health Connection					
State Regulated	21	3	14%	18	86%
Total Complaints	**21**	**3**	**14%**	**18**	**86%**
Maryland Health Insurance Plan (MHIP)					
State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**

Carrier	Total Cases	Upheld		Overturned/Modified	
MDIPA					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
MedSolutions					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Meritain Health Incorporated					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Metlife Dental Claims					
State Regulated	2	2	100%	0	0%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**3**	**3**	**100%**	**0**	**0%**
Metropolitan Life Insurance Company					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Mutual of Omaha					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
National Automatic Sprinkler Industry Welfare Fund					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
National Claims Administrative Services					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Optimum Choice					
State Regulated	4	2	50%	2	50%
Not State Regulated	2	0	0%	2	100%
Total Complaints	**6**	**2**	**33%**	**4**	**67%**

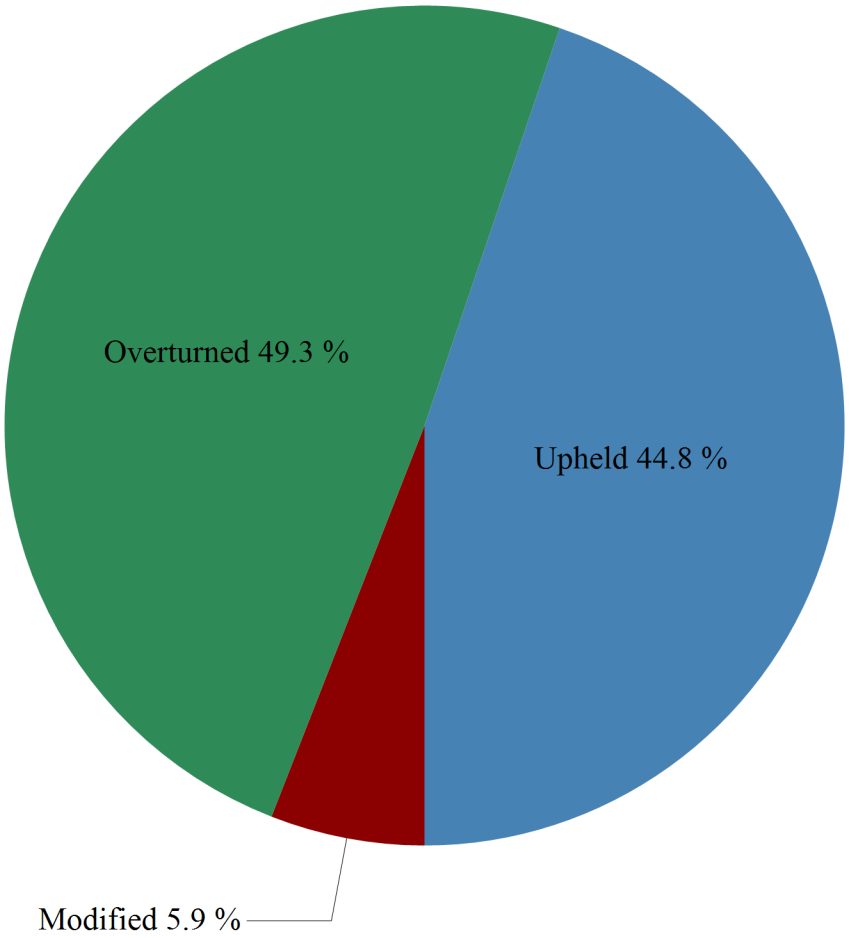
Carrier	Total Cases	Upheld		Overturned/Modified	
OptumRx, Inc.					
State Regulated	3	0	0%	3	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
Principal Life Insurance Company					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Trivergent Alliance Health					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Trusted Health Plan, Inc.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
UMR					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
United Behavioral Health					
State Regulated	3	3	100%	0	0%
Not State Regulated	3	2	67%	1	33%
Total Complaints	**6**	**5**	**83%**	**1**	**17%**
United Concordia Companies, Inc.					
State Regulated	4	1	25%	3	75%
Not State Regulated	17	11	65%	6	35%
Total Complaints	**21**	**12**	**57%**	**9**	**43%**
UnitedHealthcare					
State Regulated	57	10	18%	47	82%
Not State Regulated	76	50	66%	26	34%
Total Complaints	**133**	**60**	**45%**	**73**	**55%**
UPMC Health Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Value Options					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**

Totals					
State Regulated	327	93	28%	234	72%
Not State Regulated	339	200	59%	139	41%
TOTALS	**666**	**293**	**44%**	**373**	**56%**

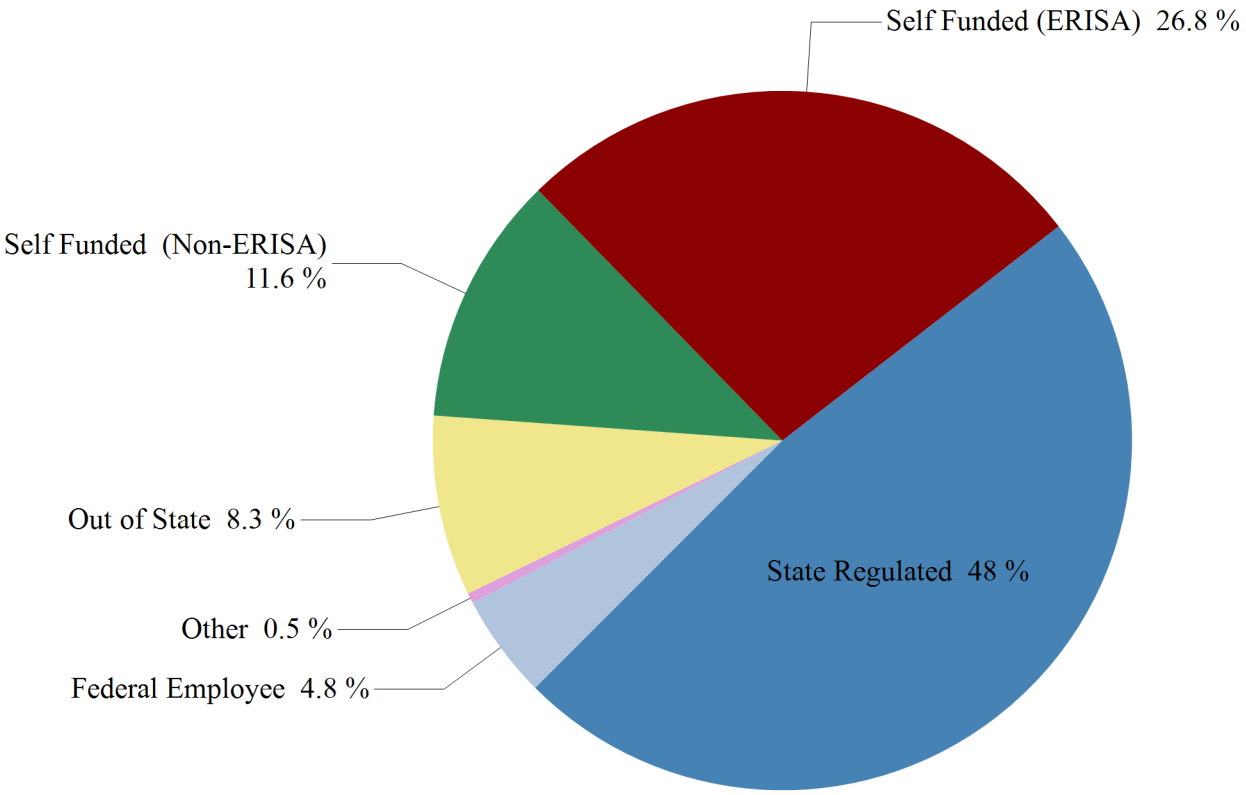
HEAU Mediated Appeals and Grievances Cases
Disposition

Carriers may uphold, overturn, or modify their decisions during the appeals and grievances process. The chart below identifies the outcomes of the Appeals and Grievances cases that the HEAU mediated and closed during FY 2016.



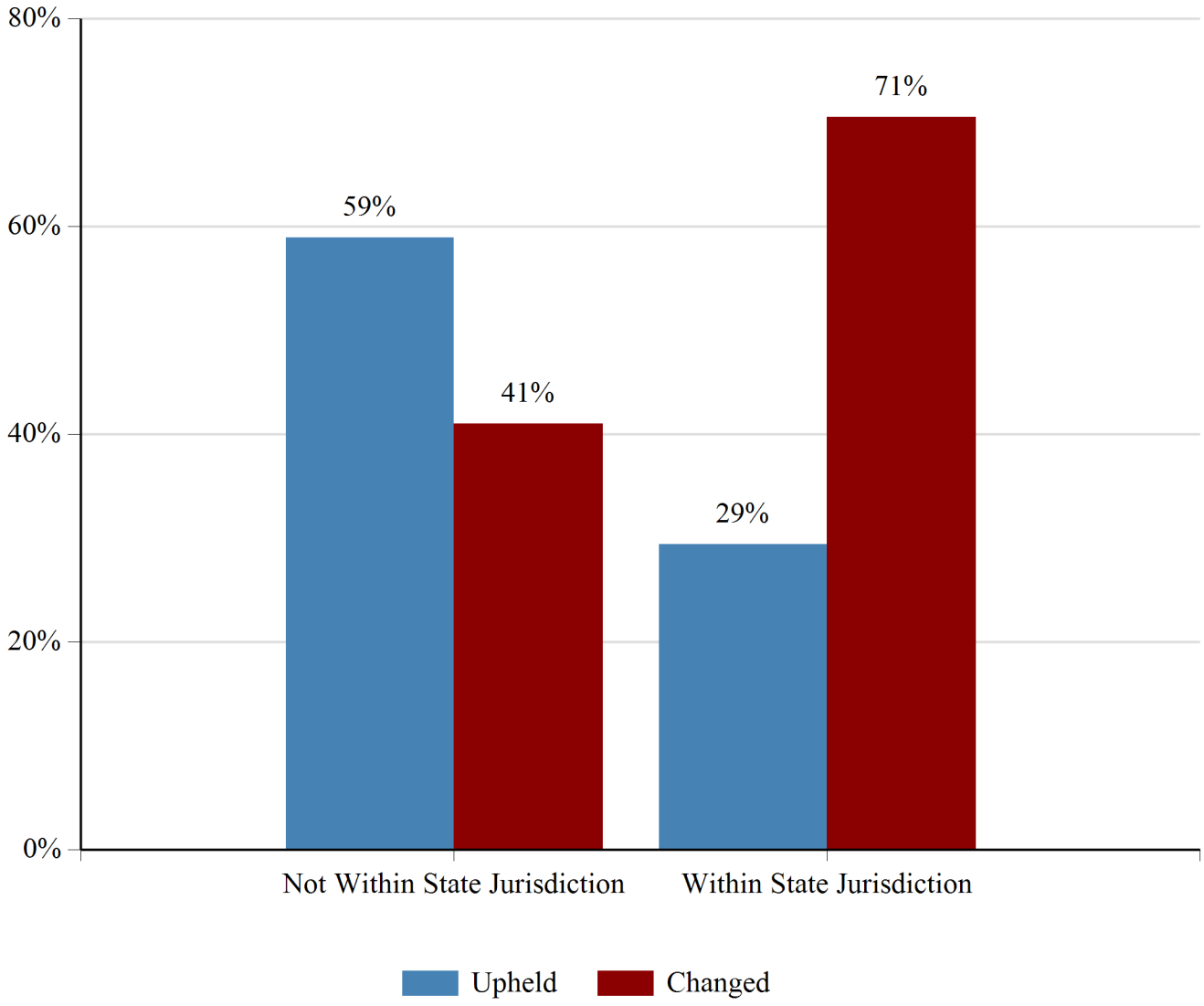
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the primary carrier types involved in the 623 Appeals and Grievances cases the HEAU mediated and closed during FY 2016.



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

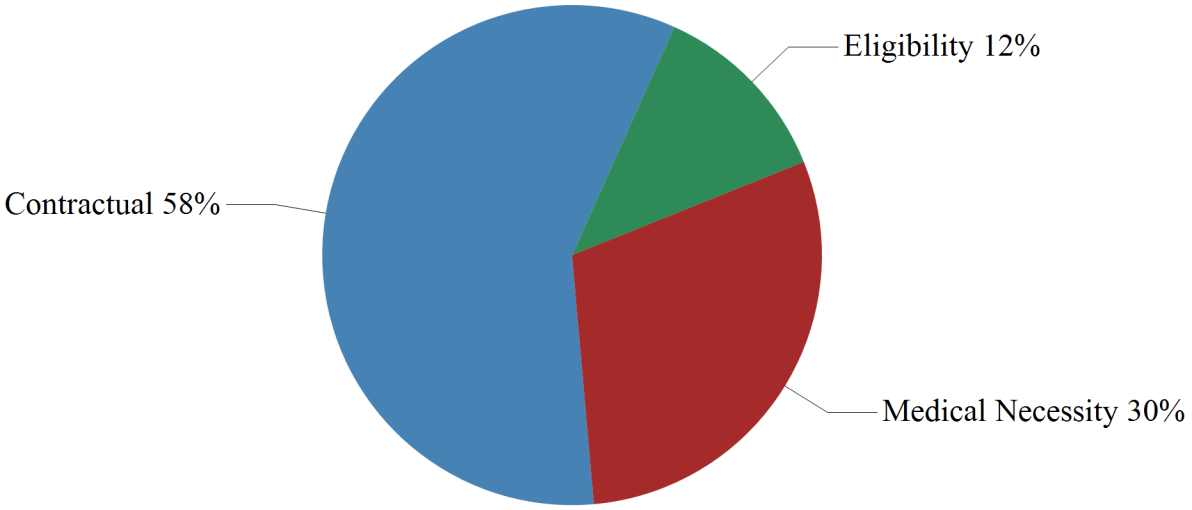
The chart below reflects the outcomes of the 623 Appeals and Grievances cases the HEAU mediated and closed during FY 2016 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

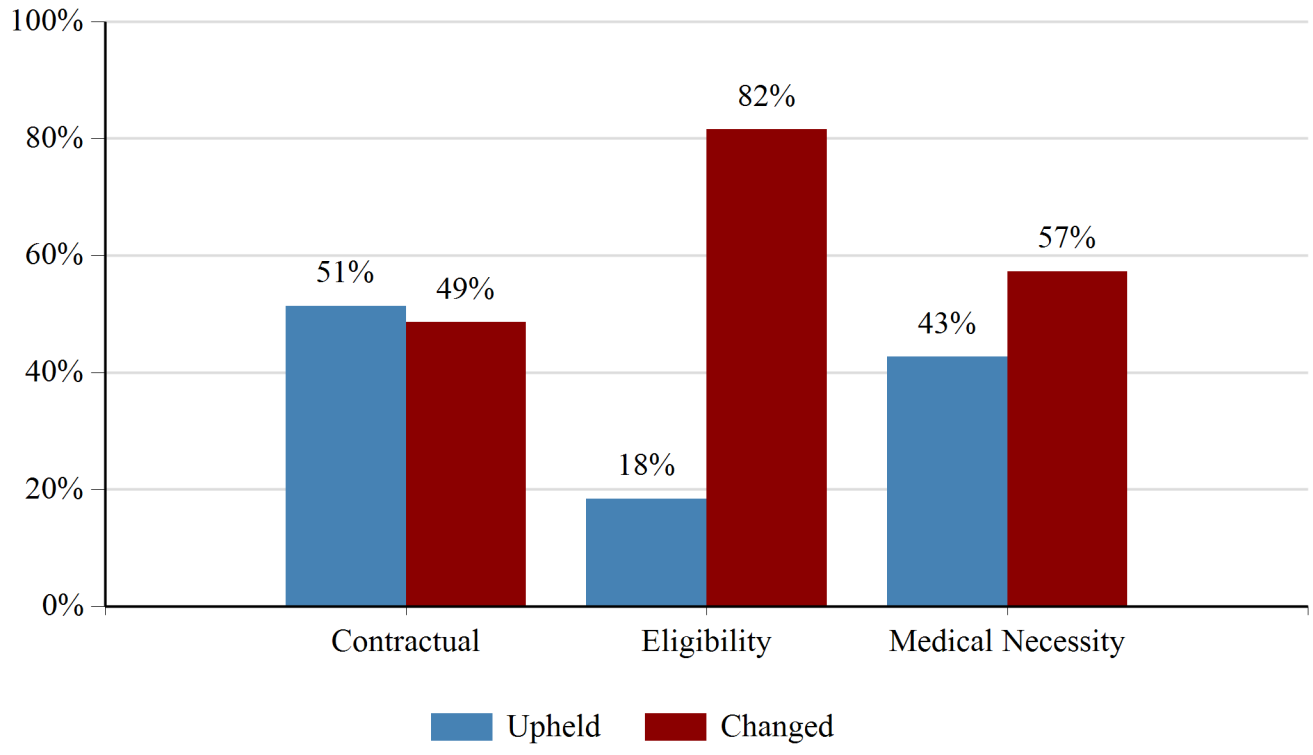
Types of Denials

The HEAU reports data on medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions). The chart below identifies the percentages of each type of case the HEAU mediated and closed during FY 2016.



Outcomes by Denial Type

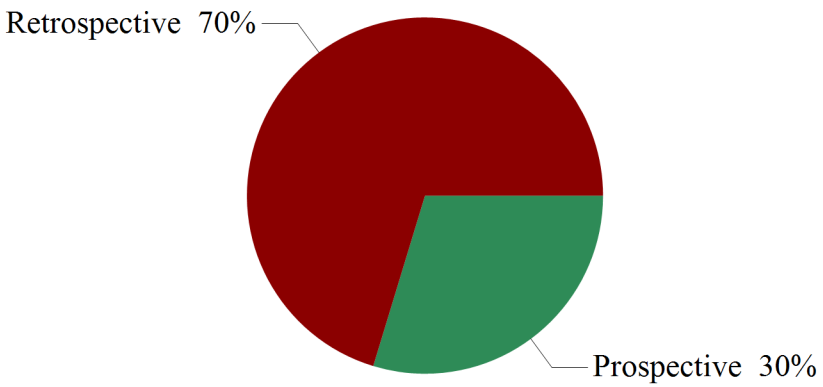
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2016.



HEAU Mediated Appeals and Grievances Cases

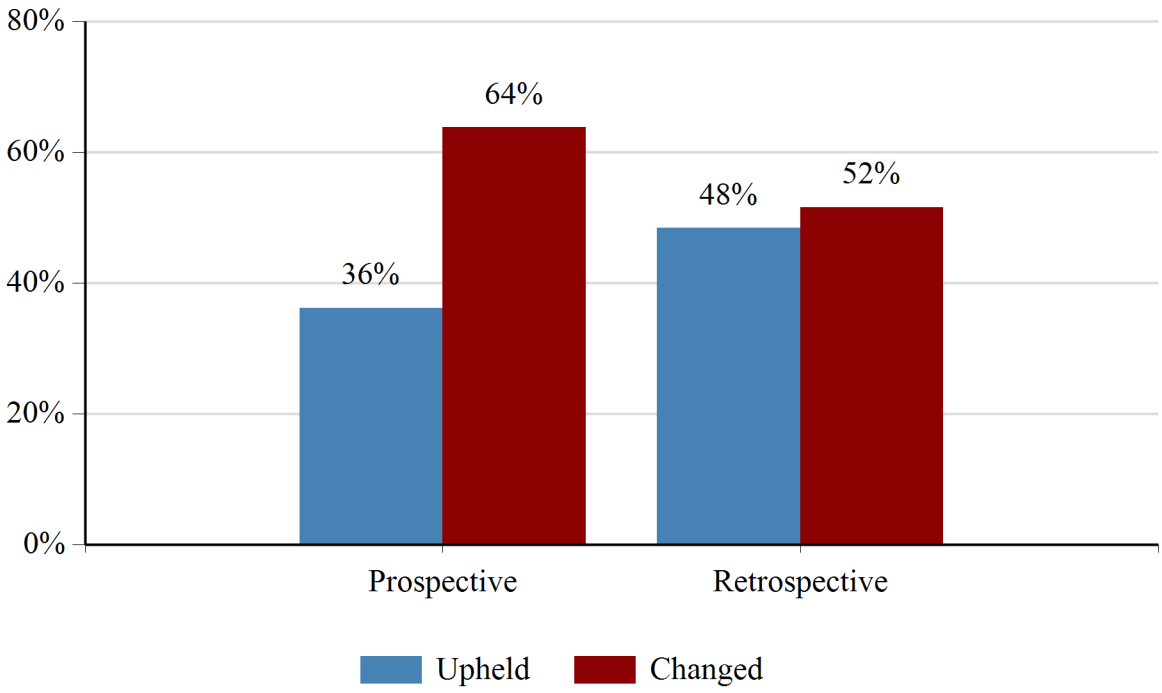
Timing of Denials

Carriers can deny coverage prior to a provider rendering a service, while a provider is rendering a service, or after a provider renders a service. The chart below identifies the percentages of the timing of carrier denials for each type of Appeals and Grievances case the HEAU mediated and closed during FY 2016. Eligibility disputes are treated as prospective denials.



Outcomes by Timing of Denials

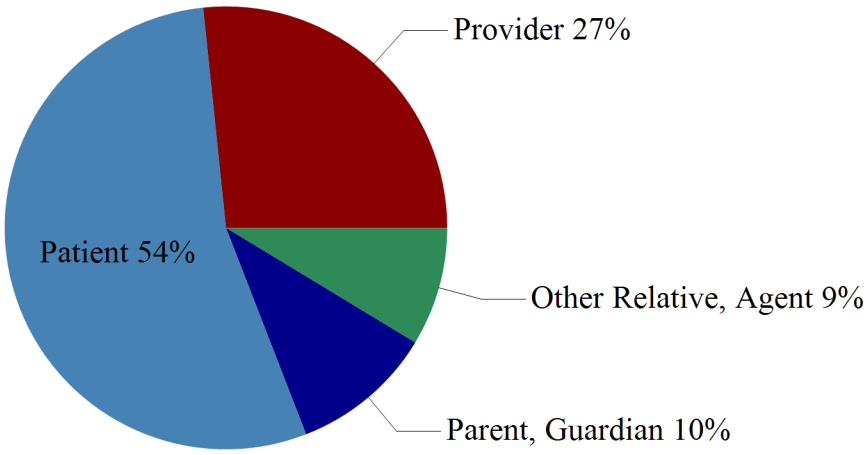
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2016 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

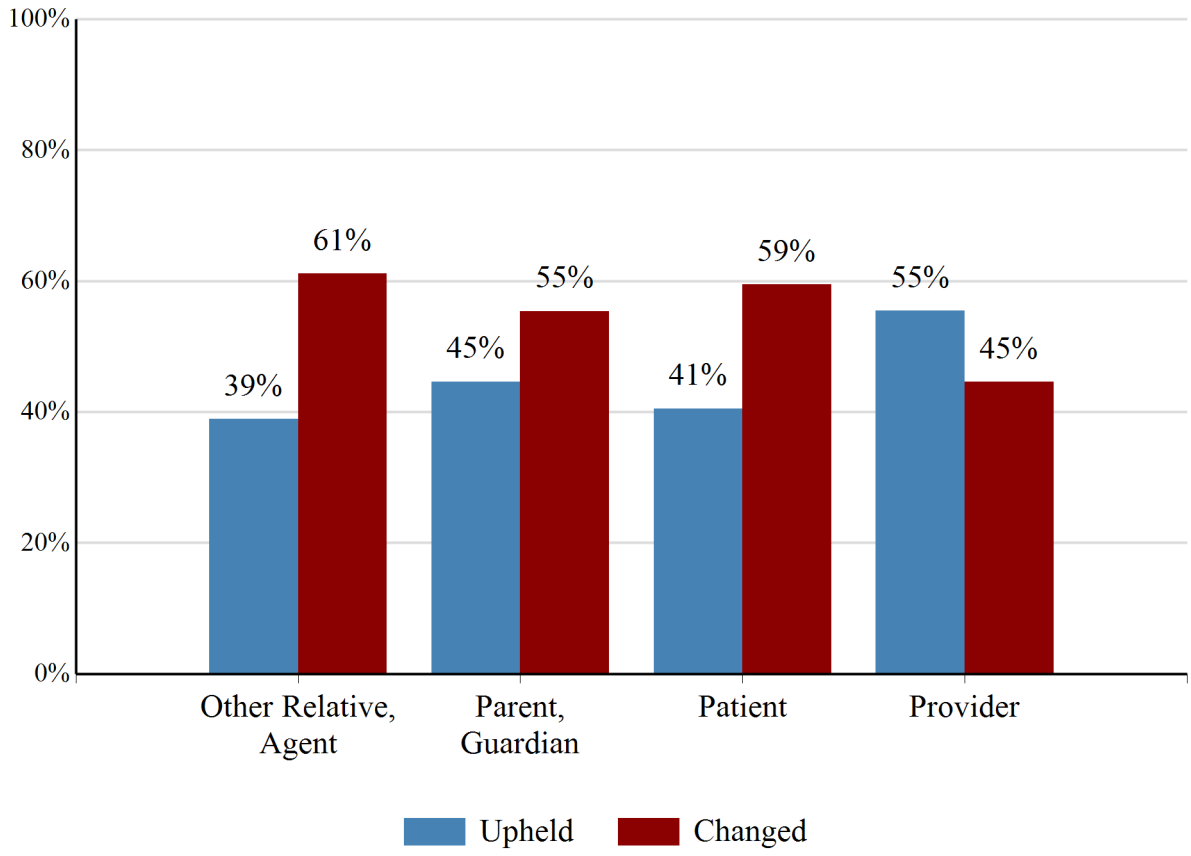
Who Filed the Case

Complaints may be filed by patients or filed on behalf of patients by providers, parents, other relatives, or other agents. The chart below shows who filed mediated Appeals and Grievances cases the HEAU closed during FY 2016.



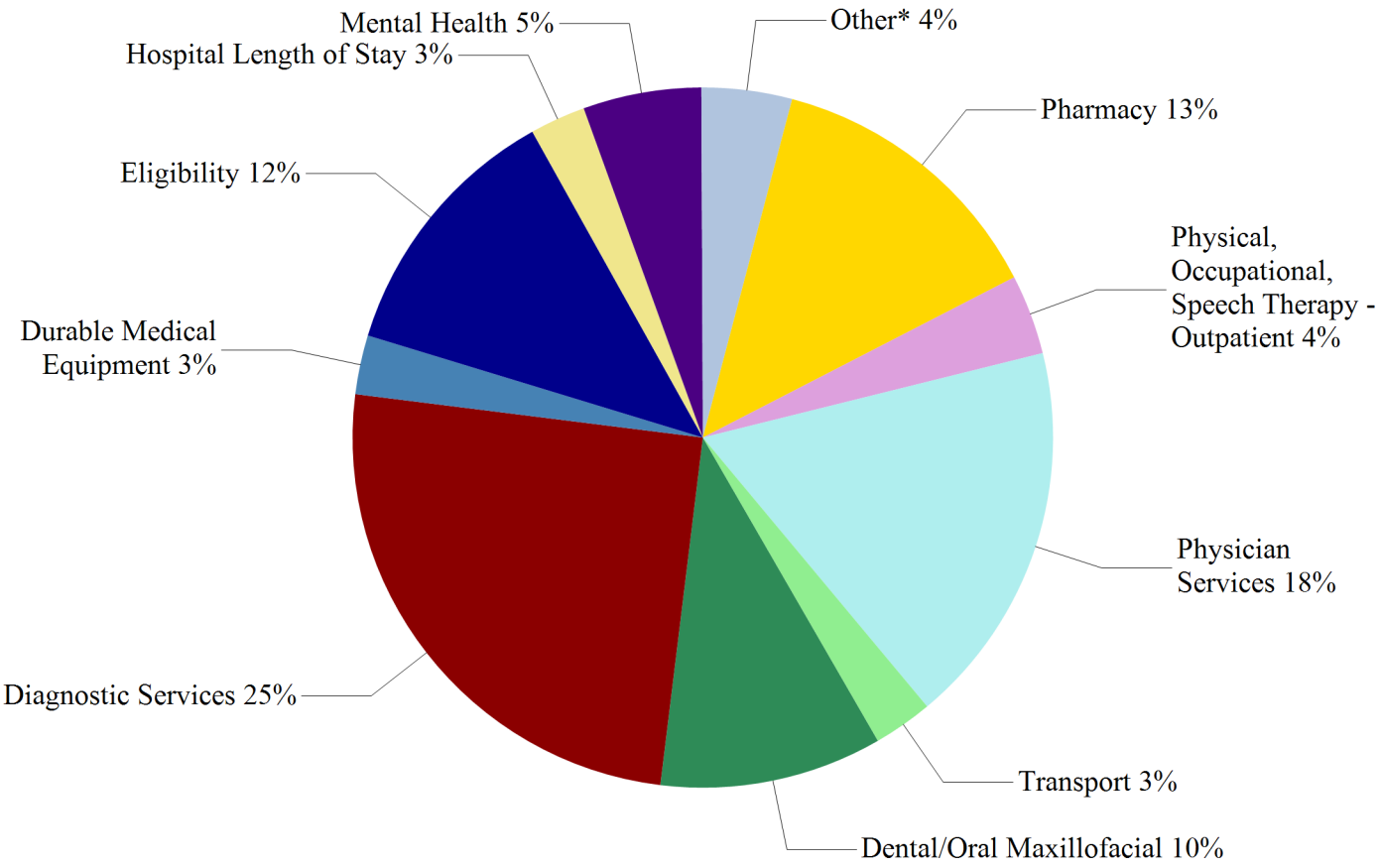
Outcomes by Who Filed the Case

The chart below reflects the outcomes, in relation to who filed the complaint, of the Appeals and Grievances cases the HEAU mediated and closed during FY 2016.



HEAU Mediated Appeals and Grievances Cases
Types of Services Denied

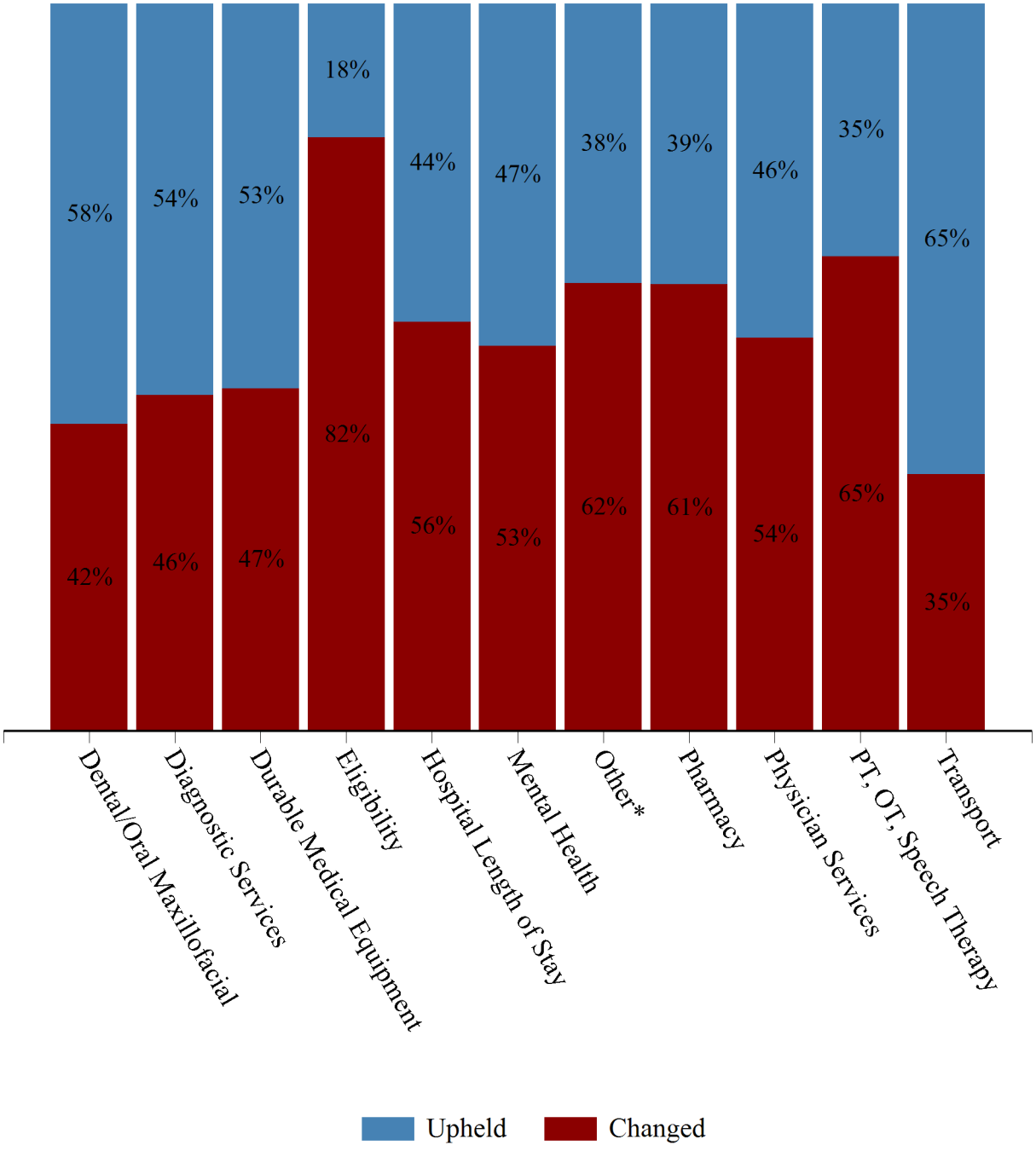
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2016.



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

HEAU Mediated Appeals and Grievances Cases
Outcomes by Service Type

The chart below compares the outcomes of the Appeals and Grievances cases the HEAU mediated and closed during FY 2016 based on the types of services denied.



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