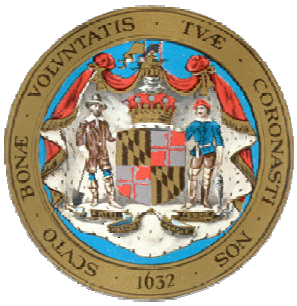

State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

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Table of Contents

I. Executive Summary 1

II. Overview of the Appeals and Grievances Process 3

III. Improvements to the Appeals and Grievances Process 4

Minimum Time for a Patient to File an Internal Grievance 4

Extension of Time for Patients to Appeal to MIA 4

Additional Reporting Requirements 4

IV. Carrier Internal Grievances Process 5

Carrier Statistics FY 2000 6

V. Maryland Insurance Administration 7

MIA Statistics FY 2000 8

VI. The Health Education and Advocacy Unit 9

HEAU Statistics FY 2000 10

VII. Positive Notes and Concerns 11

Positive Notes 11

Areas of Concern 13

VIII. Conclusion 16

VIII. Appendix 17

Carrier Grievance Data

Grievances Reported by Carriers 18
Outcomes of Internal Grievances 21
Type of Service Involved in Grievances 22
Outcomes of Grievances by Type of Service 22
Percentages of Grievances Overturned or Modified Three Year Comparison 23

MIA Complaint Data

Complaints Listed by Carrier 24
Complaints Reviewed by Appeals and Grievances Unit 26
Disposition of Complaints 27
Results of MIA Orders 28
Type of Service Involved in Complaints 29
Outcomes of Complaints by Type of Service 29

HEAU Case Data

Cases Listed by Carrier 30
Who Are Cases Filed Against? 36
Disposition of Cases 37
Who Filed Case? 38
Outcomes Based Upon Who Filed Case 38
Timing of Adverse Decision 39
Outcomes Based Upon Timing of Adverse Decision 39
Type of Service Involved in Cases 40
Outcomes of Cases by Type of Service 40
Types of Carries 41
Outcomes of Cases by Regulatory Authority 41

Letter from the Attorney General to the Maryland Congressional Delegation . . 42

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.

As required by statute, this report will cover grievances and complaints handled during the state fiscal year 2001, beginning July 1, 2000 and concluding on June 30, 2001. During this fiscal year, the Appeals and Grievances Law changed significantly as the type of decision upon which the process is predicated expanded on January 1, 2001. In addition to describing the continued implementation in the Appeals and Grievances Law, this report describes the change in the law and the changes observed as a result.

The Appeals and Grievances Law is evaluated by:

- Summarizing the provisions of the law;
- Updating changes to the law since the FY 2000 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.

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

- The expansion of the appeals and grievances process beyond "medical necessity" cases has been a tremendously significant positive development.
- The consumer assistance role performed by the HEAU is being cited as a national model for state ombudsmen.

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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 are areas of concern identified by an analysis of the cases filed under the appeals and grievances law:

- Marylanders in health plans exempt from state regulation (and MIA's external review process) do not benefit fully from the appeals and grievances process. In addition, developments at the federal legislative and judicial levels are threatening to expand the number of Marylanders who do not benefit from state insurance laws.

- As has been a continuing trend since the inception of the appeals and grievances process, patients seeking mental health and substance abuse services are far less likely to have their denials changed during the appeals and grievances process.

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.

The 2000 General Assembly passed legislation expanding the appeals and grievances process. The legislation, passed as HB 405 and entitled "Complaint Process of Coverage Decision"[4] established an appeals and grievances process for patients to challenge coverage decisions that do not involve the "medical necessity" definition contained in the original Appeals and Grievances Law. The new law allows patients to challenge any carrier's decision that results in total or partial non-coverage or non-provision of a health care service.

This law created a parallel process to the 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. These new provisions took effect on January 1, 2001.

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[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.

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

III. Improvements to the Appeals and Grievances Process

The 2001 General Assembly passed SB 856 amending the Appeals and Grievances Law to improve patient access to the appeal process and to improve the data that is collected from insurance carriers. This legislation brought about three changes in the law.

Minimum Time for a Patient to File an Internal Grievance

In response to concerns that carriers were establishing restrictive deadlines for patients to file internal grievances, the law was amended to provide that patients must have at least 180 days from the date of an adverse decision to initiate an appeal of a retrospective adverse decision. This minimum time period, which took effect on October 1, 2001 allows patients additional time to recover from a medical procedure and sort through the large amount of paperwork that typically follows a medical procedure before having to file an appeal with a carrier in response to an adverse decision.

Extension of Time for Patients to Appeal to MIA

Another deadline placed upon patients was extended. Until October 1, 2001, patients had only 30 days to appeal a carrier grievance decision to the Maryland Insurance Administration. That deadline had been the shortest non-emergency related deadline imposed upon any party in the Appeals and Grievances Law. A provision of SB 856 extended that deadline to 30 *working* days, effectively extending the deadline approximately two additional weeks in most cases. This extension should allow patients more time to evaluate a carrier grievance decision and follow the appropriate procedures to initiate a complaint regarding a grievance decision with MIA.

Additional Reporting Requirements

Beginning on January 1, 2002, carriers will be required to report more data to the MIA related to the denials that they issue. While carriers have been required since the effective date of the Appeals and Grievances Law in 1999 to report the number and types of internal grievances that they handled, there has been no data available on the number and types of adverse decisions issued by the plan. Beginning with data generated on January 1, 2002, carriers will be required to report the number of adverse decisions they issue each quarter as well as the type of service that was at issue in the adverse decision.

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, 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.

- 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.

While these limitations on carrier data have not yet been addressed, there will be more important data to report with the expanded data to be submitted by carriers beginning in 2002. New requirements passed in SB 856 in 2000 will require carriers to report the number of adverse decisions they issue and identify the type of service involved in each adverse decision. This data should offer enhanced insight into carrier decisions and the carrier grievance process. Since carriers begin reporting this data in January 1, 2002, the first six months of data will be presented in our next annual report.

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

Carrier Statistics FY 2000

In addition to the highlights listed below, charts providing statistical detail of the disposition of HEAU cases appear on pages 18-23 of this report.

- Carriers reported handling 4,640 internal grievances in FY 2001, a 14% increase over FY 2000.

- Overall, carriers changed their original decisions in approximately 56% of the grievances they received, overturning adverse decisions in 49% of cases and modifying them in 7%. This is a 5% increase from FY 2000, when carriers reported changing 51% of their adverse decisions during the internal grievance process.

- The outcomes of internal grievances vary significantly based upon the type of service that is the subject of the disputes. These trends have remained fairly constant during the past three years, with adverse decisions related to pharmacy, radiology/laboratory services, and emergency room services much more likely to be reversed than adverse decisions involving mental health care, inpatient hospital services, and physical, occupational and speech therapy.

- Adverse decisions involving mental health services continue to be significantly less likely to be overturned than other types of services. FY 2001 data represents a three-year low with carriers reversing only 24% of adverse decisions involving mental health care.

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 24-29 of this report.

- The Appeals and Grievances Unit of the MIA reviewed a total of 1,380 cases that were filed between July1, 2000 and June 30, 2001.

- After reviewing these cases, the MIA determined that 478 involved adverse decisions issued by health insurance carriers regulated by the MIA.

- MIA referred 260 of the 478 adverse decision cases 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 218 cases in which patients challenged grievance decisions issued by health insurance carriers. Carriers reversed their grievance decisions in 79 of these cases before the MIA issued an order.

- MIA issued 139 orders related to appeals and grievances cases during FY2001 with 82 (59%) upholding, 44 (32%) overturning, and 13 (9%) modifying carriers' grievance decisions.

- Of the total of 218 cases in which MIA initiated a review, the carriers' adverse decisions were overturned or modified, either voluntarily or by MIA order, in 62% of the cases.

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 conducts 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 HEAU also contacts the health insurance carrier and requests the utilization review criteria upon which the carrier's decision to deny care was based. The HEAU also requests the carrier 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. Most complaints are resolved during this information exchange process. When necessary, the HEAU will prepare and file a formal written grievance with the health insurance carrier on behalf of the patient.

If the carrier continues to deny the care at the conclusion of the grievance process 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 30-41 of this report.

- The HEAU closed 2,282 cases during FY 2001, representing a 10% increase over the number of complaints closed during FY 2000.

- In the first six months of calendar year 2001, the number of appeals and grievances cases received by the HEAU increased 89% over the similar period in 2000, due in large part to the expansion of the types of decisions subject to appeals and grievances remedies.

- The HEAU assisted patients in obtaining more than $1 million in claims payments in appeals and grievances cases in FY 2001, bringing to more than $2.75 million the total claims payments related to appeals and grievances cases since the law became effective in January 1999.

- Based upon a comparison to data reported by carriers, patients who seek assistance from the HEAU during the grievance process are more likely to have the adverse decision changed during that process than those patients who file grievances on their own. Carriers reported changing 56% of adverse decisions during the grievance process while HEAU efforts resulted in adverse decisions being changed in 70% of the cases mediated involving carriers subject to MIA regulations.

- Mediation efforts resulted in changes to carrier decisions in 52% of the cases that were filed against health plans not subject to review by MIA. Differences in outcomes related to state authority are notable in many instances even within an individual carrier's cases.

VII. Positive Notes and Concerns

Based upon the HEAU's experiences in implementing the appeals and grievances process, we have identified the following points regarding positive developments, trends and concerns we have noted.

Positive Notes

The expansion of the appeals and grievances process to cover denials based on contractual provisions beyond "medical necessity" cases has been a tremendously significant positive development.

The appeals and grievances process that has been in place since 1999 was expanded significantly when the law creating a parallel process for contractual denials took effect on January 1, 2001. Prior to that time, only patients who received denials in which carriers cited as a reason for the denial that care was "not medically necessary, appropriate, or efficient" received notices about the appeals and grievances process and were able to access services provided under that process. However, as of January 1, 2001, all patients receiving a claim or authorization denial from their health insurance carrier receive notices providing information about the appeals and grievances process, including information about contacting the HEAU for assistance and appealing grievance decisions to the MIA.

The results from this expansion have been dramatic, both in terms of the increased number of patients who contact the HEAU for assistance as well as in the individual stories of Marylanders who have benefitted from this law. Because this law took effect midway through the fiscal year covered by this report and because many of these new cases remained open at the close of the fiscal year, this report contains limited data regarding these cases. However, the HEAU has seen an 89% increase in the number of appeals and grievances cases it received during the first six months of calendar year 2001 in comparison to the first six months of calendar year 2000. From January 1 - June 30, 2001, the HEAU received 706 appeals and grievances cases, compared to 373 appeals and grievances cases during the same period in 2000.

The early data seems to indicate that the types of services involved and the outcomes of these cases are very similar to the "medical necessity" appeals and grievances cases we have been handling since the inception of the original appeals and grievances law. The effect of the new law has been to eliminate a gap through which many Marylanders with denied claims had been falling.

While the dramatic increase in numbers of cases is compelling in demonstrating the importance of this expansion of the coverage of the appeals and grievances process, it is the care and patients represented by these statistics that emphasize the importance of the law and its implementation. The following cases were subject to appeals and grievances remedies as a result of the law that took effect this year:

- The HEAU received a complaint from the father of a two-year-old child who needed extensive, long-term physical, occupational, and speech therapy as a result of complications associated with his extremely premature birth (23 weeks gestation). His health plan had denied additional therapy services for his child, citing a contractual limit on the number of rehabilitation therapy visits present in the contract. The HEAU assisted this consumer by preparing an appeal that put forth information that demonstrated that the child's need for therapy was the result of a congenital condition and therefore not limited to the rehabilitation therapy limits in the contract. As a result, the carrier overturned its adverse decision and agreed to authorize additional therapy that this child is expected to require through his developmental years.

- An 84-year-old man with diabetes became very weak and dizzy and required hospital admission for an endoscopy, colonoscopy and blood transfusions. While Medicare processed and paid claims according to their guidelines, the patient's supplemental policy denied coverage of the co-payments, indicating that treatment was for a pre-existing condition and therefore excluded from the member's contract. Upon review of the clinical records forwarded from the HEAU during the mediation process, the carrier determined that the diagnosis for which treatment was given was not a pre-existing condition and approved payment for the member's co-payment.

- A 41-year-old woman was referred by her gynecologist for an annual mammogram. Because she had a mammogram performed 18 months prior, her carrier denied coverage citing a contractual limitation of one screening mammogram every 24 months. However, the HEAU learned that the patient's contract allowed more frequent mammograms if they were recommended by a gynecologist. The HEAU was successful in having the denial overturned when a copy of a letter from the patient's gynecologist recommending annual mammograms due to a family history of breast cancer was presented to the carrier.

The passage and implementation of this law expanding the application of the appeals and grievances process represents an important development for the citizens of Maryland who need assistance. It also has been a significant enhancement to Maryland's insurance laws that continue to place Maryland in a leadership role in providing rights to patients in the managed care market.

The consumer assistance role performed by the HEAU is being cited as a national model for state ombudsmen.

On March 28, 2001, Senator Jeffords, the Health, Education, Labor, and Pensions Committee panel chairman, and Senator Jack Reed introduced the Health Care Consumers Assistance Fund Act (Act) that was cosponsored by Senators Susan Collins, Barbara Mikulski, Paul Wellstone and Hillary Clinton. The bill would provide $100 million in grants for states to establish state level agencies which would assist consumers through the grievance and appeals processes, and in obtaining information about health insurance plans, including their rights and responsibilities under various plans.

The Act was designed to build on existing state-based programs that assist health care consumers. Senate testimony highlighted the successful state programs already in place in Maryland and Vermont. Bernadette Warren, a consumer who had utilized the services of the HEAU in appealing an insurance carrier's decision, provided testimony supporting the legislation and described the services provided by the Unit. Further supporting testimony featured a national survey conducted in June 2000 by the Kaiser Family Foundation, which reported that while most people who experienced a problem with their plan were often able to resolve it, many were confused about where to go for information and help if needed.

While the future of this specific legislation is uncertain as of the writing of this report, there is growing support both in Congress and among other states to attempt to replicate the valuable ombudsman services provided in Maryland by the HEAU.

Areas of Concern

As has been a continuing trend since the inception of the appeals and grievances process, patients seeking mental health and substance abuse services are far less likely to have their denial changed during the appeals and grievances process.

In each of the first two reports on the appeals and grievances process, the HEAU noted that patients challenging adverse decisions related to mental health and substance abuse care 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. This disturbing trend continues to be evident in the data available for FY01:

- Carriers reported that only 24% of the patients challenging adverse decisions involving mental health care are successful in getting those denials overturned or modified. In comparison, 59% of patients challenging denials related to other types of services are successful.

- Carriers report that a disproportionately high number of grievances filed involved mental health care. Though down slightly in FY01, 8% of carrier grievances involved mental health care. Mental health care represents 3-5% of the health care services provided in the state.

- HEAU data indicates that a large percentage of the patients involved in these disputes are children and adolescents. In FY01, 48% of HEAU's cases involving mental health or substance abuse were filed by parents, guardians, or providers on behalf of minors.

While the Appeals and Grievances Law has been a remarkable success in many areas, it remains clear that patients seeking mental health and substance abuse treatment still experience

tremendous challenges in appealing denials. HEAU data shows that patients seeking mental health and substance abuse services were more likely to be successful in challenging adverse decisions with the assistance of the HEAU. The HEAU continues to work with patients and providers to provide this necessary assistance and to explore opportunities to address problems in this area.

Marylanders in health plans exempt from state regulation do not benefit from the appeals and grievances process. In addition, developments at the federal legislative and judicial levels have threatened to expand the number of Marylanders who do not benefit from state insurance laws.

As presented in the FY00 annual report, approximately 25% of the HEAU's appeals and grievances cases are exempt from state regulation because they involve employer self-insured plans subject to Employee Retirement Income Security Act of 1974 (ERISA)[6] regulations. HEAU mediation efforts for FY 2000 resulted in self-insured plans changing their original adverse decision in 54% of the cases, while carriers subject to state regulation changed their original adverse decision in 76% of the cases. Those numbers remained relatively fixed for FY 2001 with self-insured plans changing their original adverse decision in 52% of cases, while carriers subject to state regulation changed the adverse decisions in 70% of the cases. At present there are two pending federal actions that could effect the scope of ERISA preemptions and further limit the number of Marylanders who benefit from the state's insurance regulatory system.

First, during this coming session the Supreme Court will consider ERISA preemptions in *Rush Prudential HMO Inc. v. Moran*, (230 F.3d 959). *Moran* is a Seventh Circuit case upholding an Illinois court's finding that ERISA does not preempt state law requiring HMOs to provide an independent review of coverage denial decisions. The Attorney General and the National Association of Attorneys General will be submitting an Amicus Brief to the Supreme Court supporting the Illinois independent review law. It is important to the future of the appeals and grievances law in Maryland that the Supreme Court rule in a way that allows states to continue to implement independent review of health insurance carrier decisions.

The second action under consideration is the Patient's Bill of Rights in which Congress could expand, reduce, or clarify ERISA preemptions. At present the House and Senate have competing versions of the Patient's Bill of Rights awaiting a conference committee. It is of crucial concern to Maryland that the resulting final Congressional measure does not expand ERISA preemptions to the detriment of Maryland's Appeal and Grievance Law. To that end the Attorney General sent a letter to the Maryland Congressional Delegation expressing our concerns and requesting that the House and Senate preserve the laws of Maryland, and of other states, which were developed and implemented to provided citizens with assistance and protection. A copy of the letter is included in the appendix of this report.

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[6]ERISA establishes the regulation of employee benefit plans "as exclusively a federal concern." New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995). ERISA's general preemption clause, § 514(a), 29 U.S.C. § 1144(a), preempts "all state laws insofar as they . . . relate to any employee benefit plan."

Ideally, federal officials would act to expand states' roles in assisting patients who are covered by self-insured plans by permitting the type of meaningful assistance to all Marylanders as those who are in state-regulated plans currently enjoy. The HEAU will continue to monitor federal action in this area and, when appropriate, urge improvements in the federal law.

VIII. Conclusion

Maryland's appeals and grievances process continues to provide significant assistance to patients who wish to challenge denials from health insurance carriers. Greater information about state resources available to assist patients is available to consumers during the grievance process. The implementation efforts of the HEAU and the MIA have helped thousands of Marylanders since the law became effective in 1999. The General Assembly has continued to enhance the process by requiring better notices to patients, lengthening patient deadlines, broadening the scope of the types of denials covered, and revising data requirements to provide better information about the environment patients face in the health care market. As a result, Maryland's appeals and grievances process is regularly cited as an example of a positive, working process for our citizens.

However, we must continue to identify barriers to patient use of both health insurance carrier systems as well as the services provided by state agencies. We must continue to work with carriers and providers to assure that all parties are responsive to patients in need of care. And we must examine the results of our efforts, the data we produce, and particular problems noted even in individual cases to identify ways to improve our efforts and our process. At the same time, we must work to provide feedback at the federal level to not only assure that our state laws are preserved in this area, but to also explore opportunities to provide additional rights to those citizens whose health plans are not covered by state insurance laws.

Appendix

Carrier Grievance Data

Grievances Reported by Carriers

Fiscal Year 2001

Carrier	Upheld		Overturned		Modified		Total
Aetna U.S. Healthcare - Largo, MD	46	35%	84	65%	1	1%	130
Allianz Life Insurance Co. of North America	7	100%	0	0%	0	0%	7
American National Life Insurance Co. Of Texas	0	0%	1	100%	0	0%	1
American Republic Insurance Company	3	60%	2	40%	0	0%	5
Ameritas Life Insurance Corporation	32	78%	9	22%	0	0%	41
CapitalCare, Inc	21	64%	11	33%	1	3%	33
CareFirst of Maryland Inc.	288	57%	153	30%	67	13%	508
Celtic Insurance Company	4	40%	5	50%	1	10%	10
Celtic Life Insurance Company	6	75%	2	25%	0	0%	8
CIGNA Dental Health of Maryland	1	50%	0	0%	1	50%	2
CIGNA Healthcare Mid-Atlantic, Inc.	37	25%	103	69%	7	5%	150
Companion Life Insurance Company	3	11%	22	79%	3	11%	28
Connecticut General Life Insurance Company	137	31%	272	61%	25	6%	444
Conseco Medical Insurance Company	1	100%	0	0%	0	0%	1
Continental Casualty Company	0	0%	2	100%	0	0%	2
Continental General Insurance Company	0	0%	1	100%	0	0%	1
Coventry Health Care of Delaware	7	13%	46	87%	0	0%	53
Delmarva Health Plan, Inc.	13	68%	6	32%	0	0%	19
Dental Benefit Providers of MD, Inc.	16	41%	20	51%	3	8%	39
Educators Mutual Life Insurance Company	1	100%	0	0%	0	0%	1
Employers Health Insurance Company	1	100%	0	0%	0	0%	1

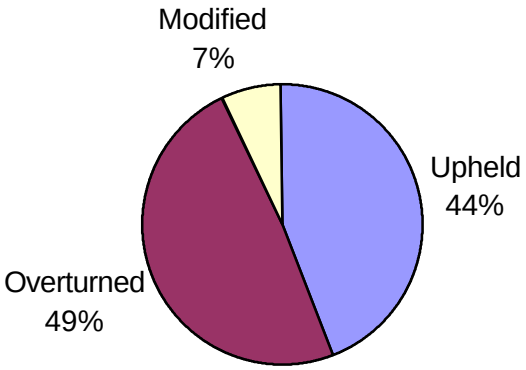
Carrier	Upheld		Overturned		Modified		Total
Fidelity Insurance Company/Maryland Fidelity Insurance Company	19	25%	42	56%	14	19%	75
Fidelity Security Life Insurance Company	1	14%	6	86%	0	0%	7
First American Financial Life Insurance Company	0	0%	2	100%	0	0%	2
Fortis Benefits	1	100%	0	0%	0	0%	1
Freestate Health Plan, Inc.	186	47%	168	43%	41	10%	395
George Washington University Health Plan	4	50%	4	50%	0	0%	8
Great West Life and Annuity Insurance Company	2	50%	0	0%	0	0%	4
Group Hospitalization and Medical Services, Inc. T/A Carefirst Blue Cross Blue Shield	35	53%	29	44%	2	3%	66
Guardian Life Insurance Company of America	17	36%	28	60%	2	4%	47
Highmark Life Insurance Company	2	67%	0	0%	0	0%	3
Kaiser Foundation	16	20%	64	80%	0	0%	80
Kaiser Permanente Insurance Company	56	24%	173	76%	0	0%	229
M.D. IPA	138	59%	72	31%	22	9%	232
MAMSI Life and Health Insurance Company	245	59%	139	34%	29	7%	413
Mid-Atlantic Vision Services, Inc.	1	100%	0	0%	0	0%	1
Mutual of Omaha Insurance Company	4	44%	3	33%	2	22%	9
Nationwide Life Insurance Company	1	100%	0	0%	0	0%	1
New England Life Insurance Company	1	100%	0	0%	0	0%	1
Optimum Choice, Inc.	475	61%	242	31%	65	8%	782
Pacific Life and Annuity	1	14%	6	86%	0	0%	7
Pacific Life Insurance Company	0	0%	1	100%	0	0%	1
Preferred Health Network	59	60%	28	28%	8	8%	99

Carrier	Upheld		Overturned		Modified		Total
Principal Life Insurance Company	0	0%	1	100%	0	0%	1
Provident American Life and Health Insurance Company	1	100%	0	0%	0	0%	1
Provident Indemnity Life Insurance Co.	1	100%	0	0%	0	0%	1
Prudential HealthCare Plan, Inc.	4	15%	21	81%	1	4%	26
Prudential Insurance Company of America, Inc.	4	50%	4	50%	0	0%	8
Reliance Standard Life Insurance Company	2	67%	1	33%	0	0%	3
Reliastar Life Insurance Company	0	0%	1	100%	0	0%	1
The Mega Life and Health Insurance Company	4	100%	0	0%	0	0%	4
Trustmark Insurance Company	23	61%	13	34%	2	5%	38
UNICARE Life and Health Insurance Company	1	100%	0	0%	0	0%	1
Union Labor Life Insurance Company	3	33%	0	0%	0	0%	9
United Concordia Dental Plans, Inc.	19	32%	36	60%	5	8%	60
United Concordia Insurance Company	1	50%	1	50%	0	0%	2
United Concordia Life and Health Insurance Company	2	17%	10	83%	0	0%	12
United Health Care of the Mid-Atlantic	42	51%	35	43%	5	6%	82
United HealthCare Insurance Company	3	100%	0	0%	0	0%	3
United of Omaha Life Insurance Company	14	35%	26	65%	0	0%	40
United Wisconsin Life Insurance Company	13	3%	378	94%	7	2%	401
Total	**2025**	**44%**	**2273**	**49%**	**314**	**7%**	**4640**

Carrier Grievance Data

Outcomes of Internal Grievances

FY 2001

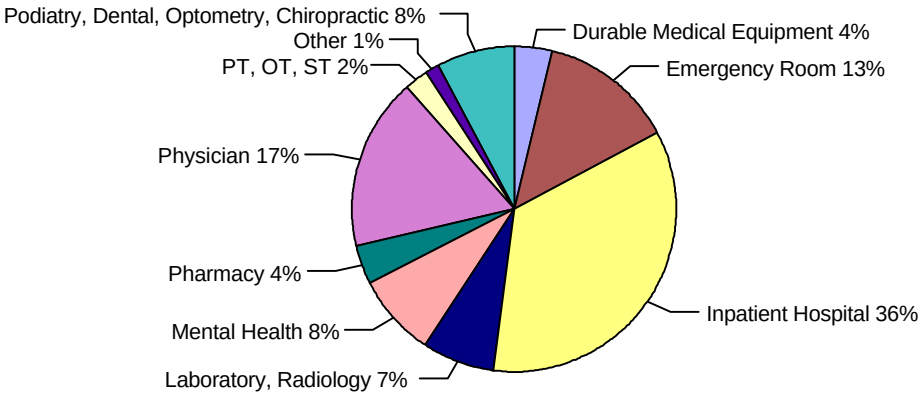


This chart describes the outcomes of the 4640 internal grievances reported by carriers during FY 2001.

Carrier Grievance Data

Type of Service Involved in Grievances

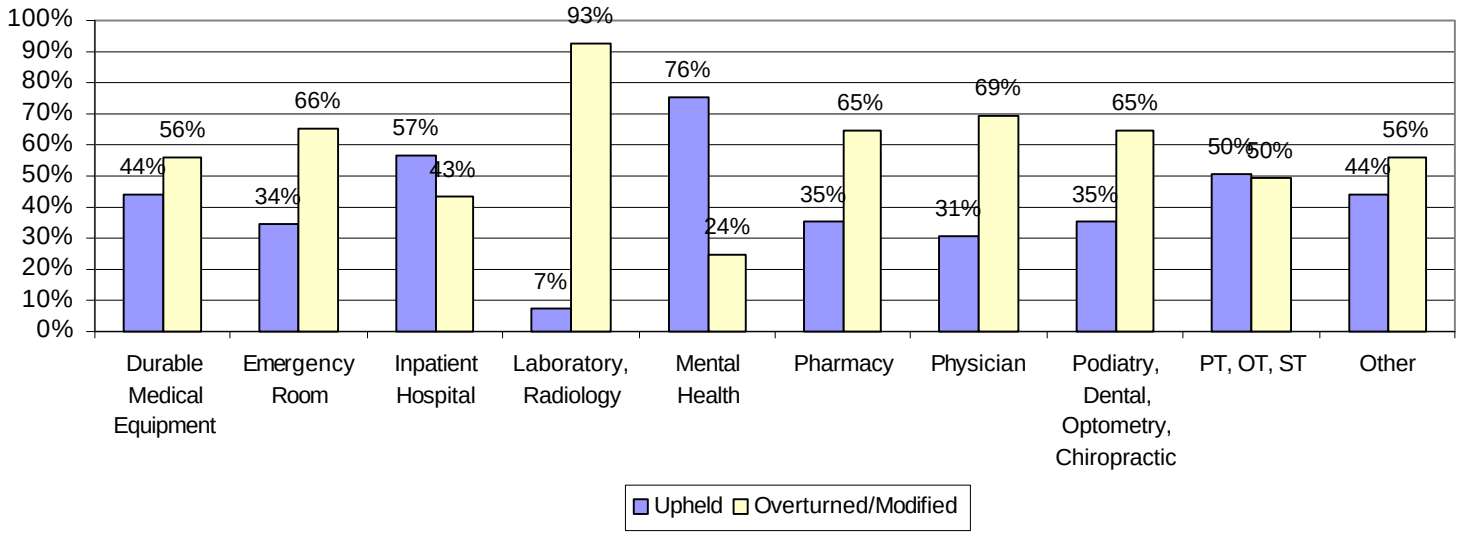
FY 2001



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 2001.

Outcomes of Grievances by Type of Service

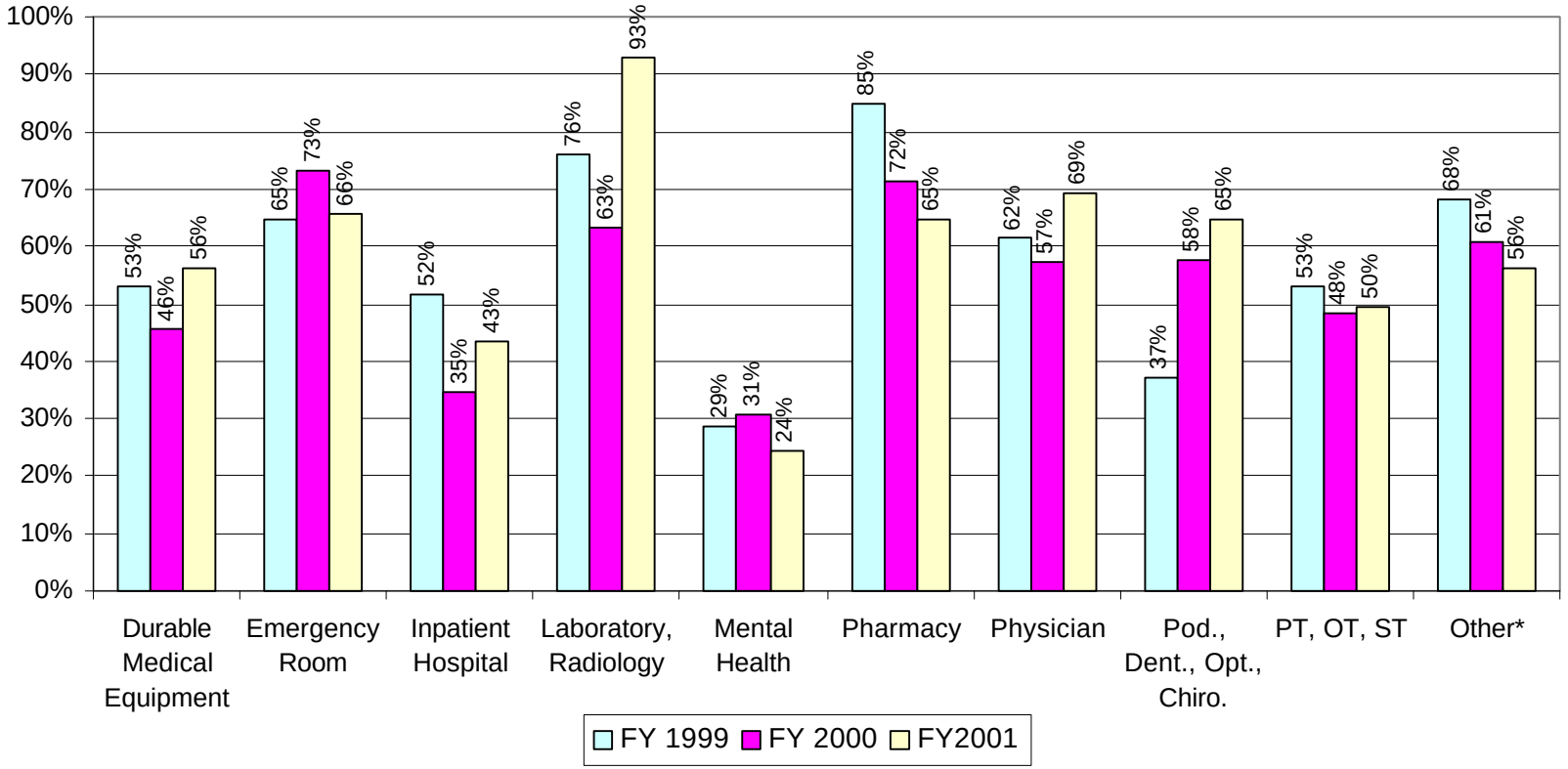
FY 2001



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

Carrier Grievance Data

Percentage of Grievances Overturned or Modified
Three Year 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, comparing FY 1999*, FY 2000, and FY 2001 outcomes as reported by the carriers.

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

MIA Appeals and Grievances Complaints

Complaints Listed by Carrier

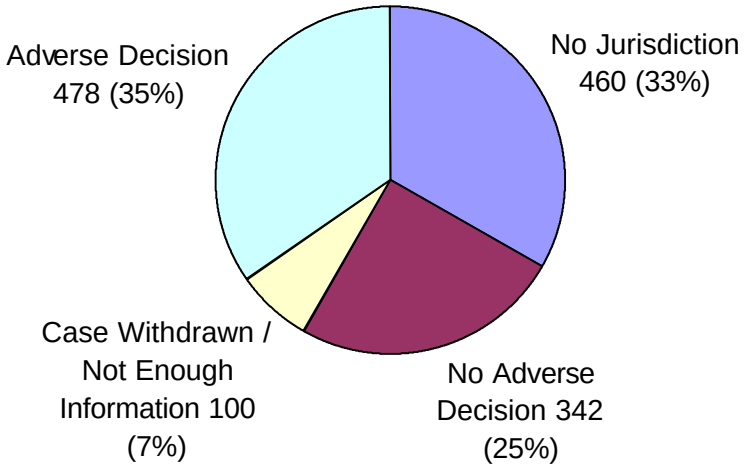
FY 2001

Carrier	Total	Carrier Upheld by MIA		Carrier Reversed by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
Aetna USHealthcare	23	6	26%	5	22%	1	4%	11	48%
American Republic	1	0	0%	0	0%	0	0%	1	100%
Blue Cross & Blue Shield of MD	55	21	38%	8	15%	7	13%	19	35%
Capital Care	3	0	0%	1	33%	0	0%	2	67%
CIGNA HealthCare Mid-Atlantic	11	4	36%	3	27%	0	0%	4	36%
Companion Life Ins. Co	1	0	0%	0	0%	0	0%	1	100%
Coventry Health & Life Insurance Co.	4	1	25%	1	25%	0	0%	2	50%
Delmarva Health Plan	4	0	0%	0	0%	1	25%	3	75%
Fortis Benefits Ins. Co.	1	1	100%	0	0%	0	0%	0	0%
FreeState Health Plan	18	4	22%	1	6%	0	0%	13	72%
George Washington Univ. Health Plan	3	2	67%	1	33%	0	0%	0	0%
Group Hospitalization & Medical Services	4	0	0%	1	25%	0	0%	3	75%
Guardian Life Insurance Co.	2	1	50%	0	0%	0	0%	1	50%
Humana Group	1	0	0%	1	100%	0	0%	0	0%
Kaiser Permanente	8	3	38%	3	38%	0	0%	2	25%
MAMSI Life and Health Insurance Co.	30	17	57%	7	23%	2	7%	4	13%
MDIPA	2	0	0%	2	100%	0	0%	0	0%
Metropolitan Life Ins. Co.	1	1	100%	0	0%	0	0%	0	0%
Mutual of Omaha	1	0	0%	0	0%	0	0%	1	100%
Optimum Choice	20	11	55%	2	10%	0	0%	7	35%

Carrier	Total	Carrier Upheld by MIA		Carrier Reversed by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
PHN-HMO	3	0	0%	1	33%	1	33%	1	33%
Phoenix American	1	1	100%	0	0%	0	0%	0	0%
Prudential HealthCare	6	3	50%	1	17%	1	17%	1	17%
Unicare Life & Health	1	1	100%	0	0%	0	0%	0	0%
United Concordia	2	1	50%	1	50%	0	0%	0	0%
United HealthCare of the Mid-Atlantic	4	1	25%	2	50%	0	0%	1	25%
United Wisconsin	1	0	0%	0	0%	0	0%	1	100%
Washington National	1	0	0%	1	100%	0	0%	0	0%
Unknown/Unspecified/Not Listed	6	3	50%	2	33%	0	0%	1	17%
TOTAL	**218**	**82**	**38%**	**44**	**20%**	**13**	**6%**	**79**	**36%**

MIA Complaints

Complaints Reviewed by Appeals and Grievances Unit FY 2001



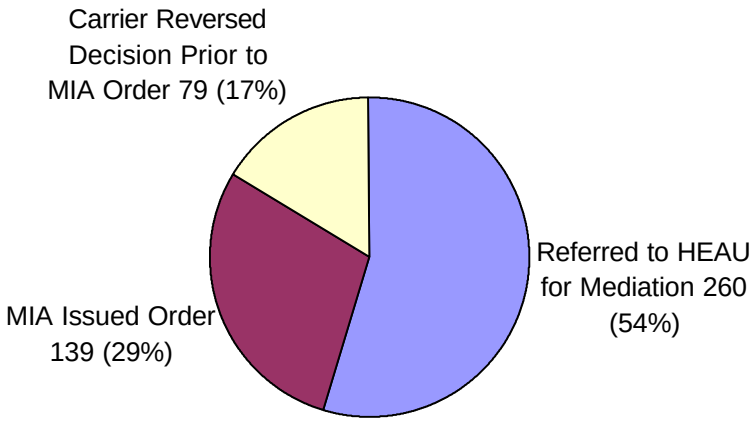
When the MIA Appeals and Grievances Unit receives a written complaint, it reviews it to determine:

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

Some cases are withdrawn or there is not enough information to complete the review. This chart details the outcomes of MIA's review of cases during FY 2001.

MIA Appeals and Grievances Complaints

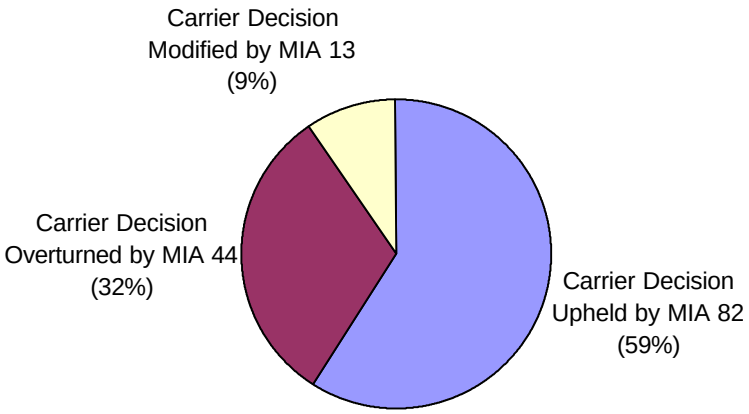
Disposition of Complaints
FY 2001



During FY 2001, MIA determined that 478 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 review process or resulted in an MIA order.

MIA Appeals and Grievances Complaints

Results of MIA Orders
FY 2001

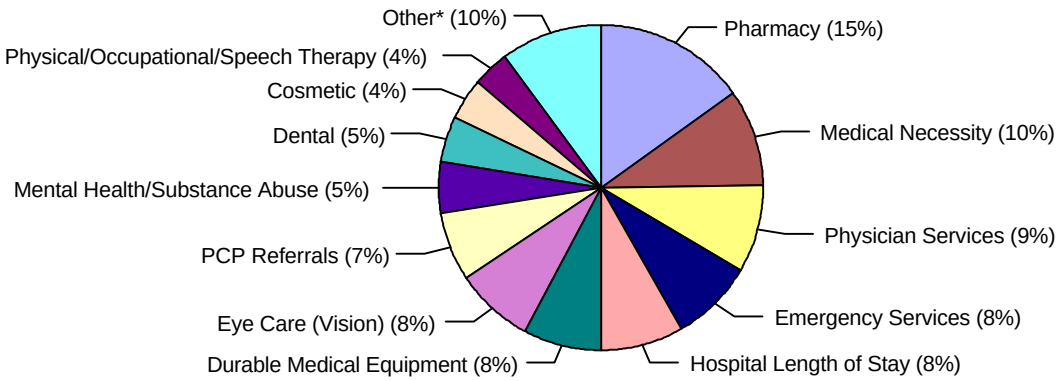


MIA issued 139 orders related to Appeals and Grievances Complaints during FY 2001. This chart describes the outcomes of those orders.

MIA Appeals and Grievances Complaints

Type of Service Involved in Complaints

FY 2001



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

* Includes Chiropractic, Experimental, In-Patient Rehabilitation, Lab, Imaging, Testing, Home Health Care and Skilled Nursing.

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	33	14	42%	6	18%	0	0%	13	39%
Medical Necessity	21	8	38%	6	29%	2	10%	5	24%
Physician Services	19	7	37%	2	11%	2	11%	8	42%
Emergency Services	18	7	39%	3	17%	0	0%	8	44%
Hospital Length of Stay	18	4	22%	6	33%	3	17%	5	28%
Durable Medical Equipment	17	8	47%	1	6%	2	12%	6	35%
Eye Care (Vision)	17	8	47%	3	18%	1	6%	5	29%
PCP Referrals	15	6	40%	3	20%	0	0%	6	40%
Mental Health/Substance Abuse	11	2	18%	2	18%	2	18%	5	45%
Dental	10	4	40%	1	10%	0	0%	5	50%
Cosmetic	9	2	22%	4	44%	0	0%	3	33%
Physical/Occupational/Speech Therapy	8	1	13%	2	25%	1	13%	4	50%
Chiropractic	6	1	17%	3	50%	0	0%	2	33%
Experimental	6	5	83%	0	0%	0	0%	1	17%
In-Patient Rehabilation	4	3	75%	0	0%	0	0%	1	25%
Lab, Imaging, Testing	4	1	25%	2	50%	0	0%	1	25%
Home Health Care	1	0	0%	0	0%	0	0%	1	100%
Skilled Nursing	1	1	100%	0	0%	0	0%	0	0%
TOTAL	**218**	**82**	**38%**	**44**	**20%**	**13**	**6%**	**79**	**36%**

This chart shows the outcomes of Appeals and Grievances Complaints handled by the MIA during FY 2001. 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 2001

HEAU Appeals & Grievances Cases by Carrier		Overturned/Modified		Upheld		All Relief
Aetna US Healthcare	Not State Regulated	32	73%	12	27%	44
	State Regulated	18	72%	7	28%	25
	Total HEAU Complaints	**50**	**72%**	**19**	**28%**	**69**
Alliance	Not State Regulated	0	0%	1	100%	1
	State Regulated	2	100%	0	0%	2
	Total HEAU Complaints	**2**	**67%**	**1**	**33%**	**3**
American Medical Security	Not State Regulated	0	0%	1	100%	1
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**1**	**50%**	**1**	**50%**	**2**
American Republic 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**
Blue Cross Blue Shield of Georgia	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Blue Cross Blue Shield of Michigan	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Blue Cross Blue Shield of the National Capital Area	Not State Regulated	1	50%	1	50%	2
	State Regulated	1	50%	1	50%	2
	Total HEAU Complaints	**2**	**50%**	**2**	**50%**	**4**
Blue Cross Blue Shield Trigon	Not State Regulated	1	25%	3	75%	4
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**25%**	**3**	**75%**	**4**
Capital Care	Not State Regulated	1	50%	1	50%	2
	State Regulated	1	50%	1	50%	2
	Total HEAU Complaints	**2**	**50%**	**2**	**50%**	**4**
CareFirst	Not State Regulated	23	42%	32	58%	55
	State Regulated	63	74%	22	26%	85
	Total HEAU Complaints	**86**	**61%**	**54**	**39%**	**140**
CareFirst Administrators	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**

HEAU Appeals & Grievances Cases by Carrier		Overturned/Modified		Upheld		All Relief
Carolinas Healthcare System	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
CIGNA	Not State Regulated	11	58%	8	42%	19
	State Regulated	10	71%	4	29%	14
	Total HEAU Complaints	**21**	**64%**	**12**	**36%**	**33**
CIGNA Dental	Not State Regulated	0	0%	0	0%	0
	State Regulated	0	0%	1	100%	1
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
CIGNA Healthcare for Seniors	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Connecticut General Life Insurance Company	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
CoreSource, A Trustmark Company	Not State Regulated	0	0%	2	100%	2
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**2**	**100%**	**2**
CoreStar	Not State Regulated	2	67%	1	33%	3
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**2**	**67%**	**1**	**33%**	**3**
Coventry Health Care	Not State Regulated	1	50%	1	50%	2
	State Regulated	5	100%	0	0%	5
	Total HEAU Complaints	**6**	**86%**	**1**	**14%**	**7**
Delmarva Health Plan	Not State Regulated	1	50%	1	50%	2
	State Regulated	1	33%	2	67%	3
	Total HEAU Complaints	**2**	**40%**	**3**	**60%**	**5**
Delta Dental Plan	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Electrical Welfare Trust Fund	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Employee Security, Inc.	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**

HEAU Appeals & Grievances Cases by Carrier		Overturned/Modified		Upheld		All Relief
Fidelity Insurance	Not State Regulated	0	0%	4	100%	4
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**4**	**100%**	**4**
Fountainhead Administrators, Inc.	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Freestate Health Plan	Not State Regulated	6	55%	5	45%	11
	State Regulated	12	75%	4	25%	16
	Total HEAU Complaints	**18**	**67%**	**9**	**33%**	**27**
George Washington University Health Plan	Not State Regulated	1	100%	0	0%	1
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**2**	**100%**	**0**	**0%**	**2**
Government Employees Hospital Association (GEHA)	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Great West Life & Annuity	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Group Benefit Services (GBS)	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	2	100%	0	0%	2
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**3**	**100%**	**0**	**0%**	**3**
Health Scope Benefits	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Humana Employers Health	Not State Regulated	0	0%	0	0%	0
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Humana Insurance Company	Not State Regulated	1	100%	0	0%	1
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**2**	**100%**	**0**	**0%**	**2**
Innovative Health Services	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**

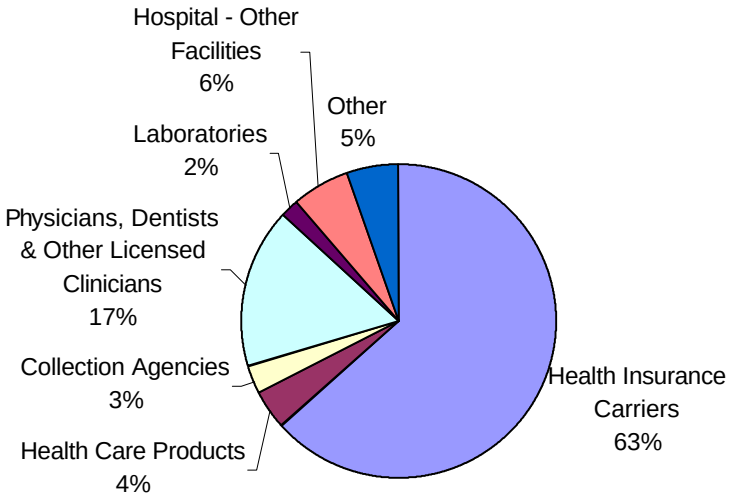
HEAU Appeals & Grievances Cases by Carrier		Overturned/Modified		Upheld		All Relief
Jardine Group Services Plan	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Johns Hopkins Employer Health Plan	Not State Regulated	5	71%	2	29%	7
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**5**	**71%**	**2**	**29%**	**7**
Kaiser Permanente	Not State Regulated	2	40%	3	60%	5
	State Regulated	6	60%	4	40%	10
	Total HEAU Complaints	**8**	**53%**	**7**	**47%**	**15**
Kaiser Senior Select Program	Not State Regulated	3	60%	2	40%	5
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**3**	**60%**	**2**	**40%**	**5**
Magellan Behavioral Health	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
MAMSI Life & Health Insurance Company	Not State Regulated	3	50%	3	50%	6
	State Regulated	6	50%	6	50%	12
	Total HEAU Complaints	**9**	**50%**	**9**	**50%**	**18**
MDIPA	Not State Regulated	0	0%	4	100%	4
	State Regulated	1	50%	1	50%	2
	Total HEAU Complaints	**1**	**17%**	**5**	**83%**	**6**
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**
Medicare Part B Trailblazers	Not State Regulated	3	100%	0	0%	3
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**3**	**100%**	**0**	**0%**	**3**
MediCareFirst	Not State Regulated	9	69%	4	31%	13
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**10**	**71%**	**4**	**29%**	**14**
Metlife	Not State Regulated	3	75%	1	25%	4
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**3**	**75%**	**1**	**25%**	**4**
Nylcare	Not State Regulated	0	0%	0	0%	0
	State Regulated	2	100%	0	0%	2
	Total HEAU Complaints	**2**	**100%**	**0**	**0%**	**2**

HEAU Appeals & Grievances Cases by Carrier		Overturned/Modified		Upheld		All Relief
Optimum Choice	Not State Regulated	1	17%	5	83%	6
	State Regulated	9	53%	8	47%	17
	Total HEAU Complaints	**10**	**43%**	**13**	**57%**	**23**
Orange County Foundation for Medical Care	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Performax	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
Phoenix American Life 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**
Preferred Health Network	Not State Regulated	0	0%	0	0%	0
	State Regulated	5	83%	1	17%	6
	Total HEAU Complaints	**5**	**83%**	**1**	**17%**	**6**
Principal Financial Group	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Priority Partners	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Prudential	Not State Regulated	7	70%	3	30%	10
	State Regulated	5	56%	4	44%	9
	Total HEAU Complaints	**12**	**63%**	**7**	**37%**	**19**
Regence Life and Health 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**
Regency Blue Cross Blue Shield of Oregon	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
SAI Med Health Plan	Not State Regulated	2	50%	2	50%	4
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**2**	**50%**	**2**	**50%**	**4**
The Loomis Company	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**

HEAU Appeals & Grievances Cases by Carrier		Overturned/Modified		Upheld		All Relief
Tricare	Not State Regulated	1	50%	1	50%	2
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**50%**	**1**	**50%**	**2**
TriState Health Partners	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Unicare/North Carolina PPO	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**0**	**0%**	**1**	**100%**	**1**
Union Labor Life Insurance	Not State Regulated	0	0%	1	100%	1
	State Regulated	0	0%	1	100%	1
	Total HEAU Complaints	**0**	**0%**	**2**	**100%**	**2**
United Concordia Companies, Inc.	Not State Regulated	0	0%	1	100%	1
	State Regulated	1	100%	0	0%	1
	Total HEAU Complaints	**1**	**50%**	**1**	**50%**	**2**
United Health Care Options	Not State Regulated	1	100%	0	0%	1
	State Regulated	0	0%	0	0%	0
	Total HEAU Complaints	**1**	**100%**	**0**	**0%**	**1**
United Healthcare of the Mid-Atlantic	Not State Regulated	5	42%	7	58%	12
	State Regulated	11	65%	6	35%	17
	Total HEAU Complaints	**16**	**55%**	**13**	**45%**	**29**
United Wisconsin Life 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**
Total	**Not State Regulated**	**146**	**53%**	**128**	**47%**	**274**
	State Regulated	**168**	**69%**	**74**	**31%**	**242**
	Total HEAU Complaints	**314**	**61%**	**202**	**39%**	**516**

HEAU Cases

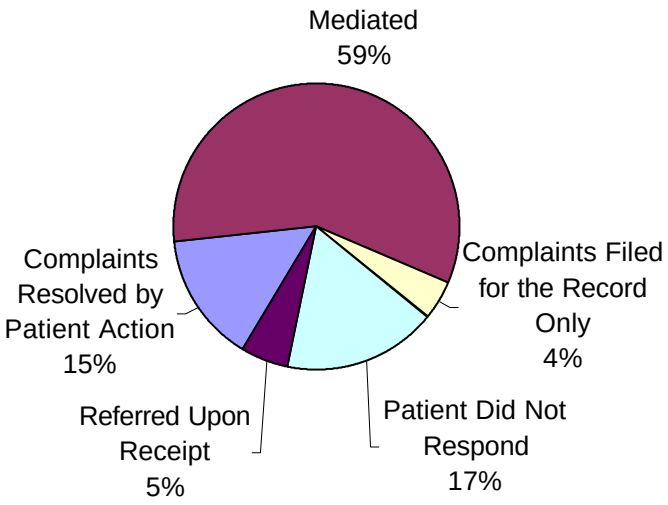
Who Are Cases Filed Against?
FY 2001



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 2001.

HEAU Appeals and Grievances Cases

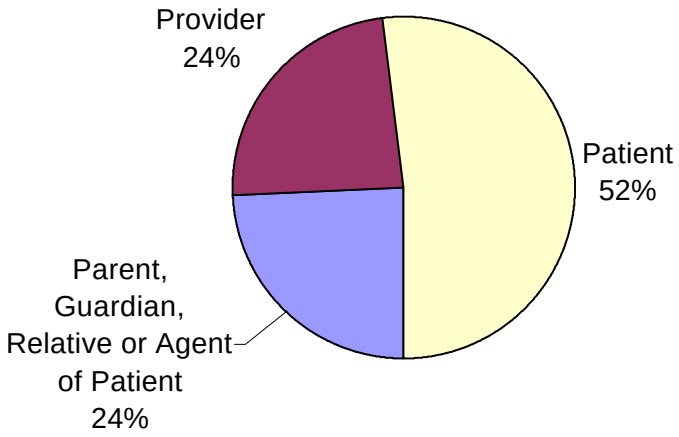
Disposition of Cases
FY 2001



The HEAU closed 883 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 17% 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 2001.

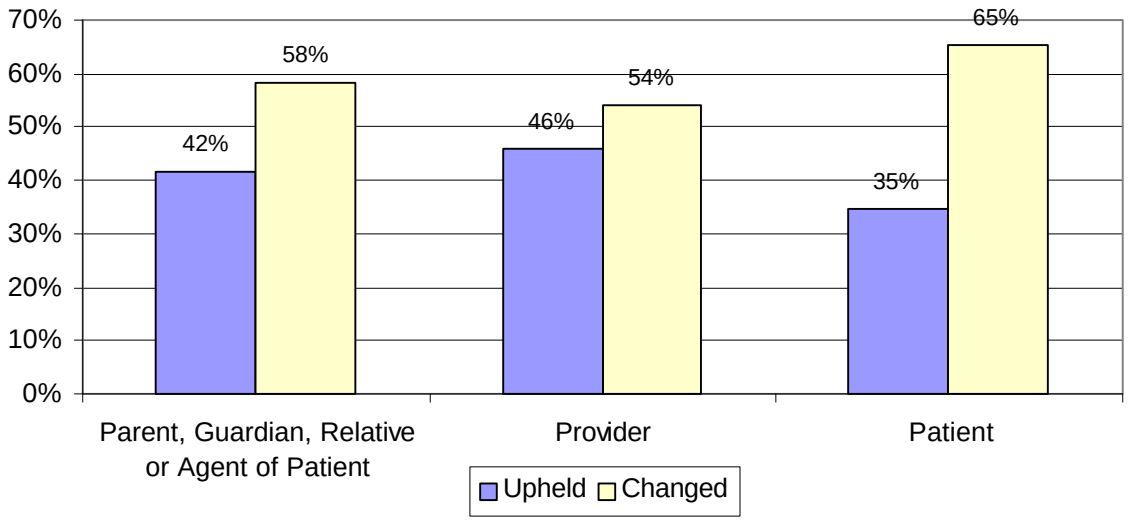
HEAU Appeals and Grievances Cases

Who Filed Case?
FY 2001



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.

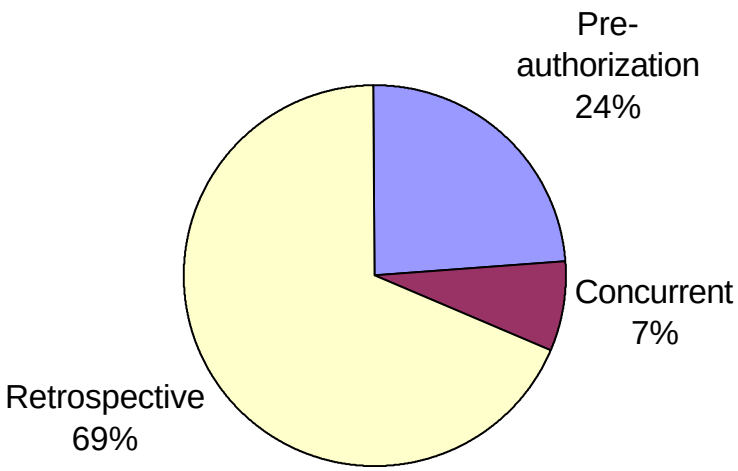
Outcomes Based Upon Who Filed Case
FY 2001



This chart shows the outcome of Appeals and Grievances Cases mediated by the HEAU during FY 2001. 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.

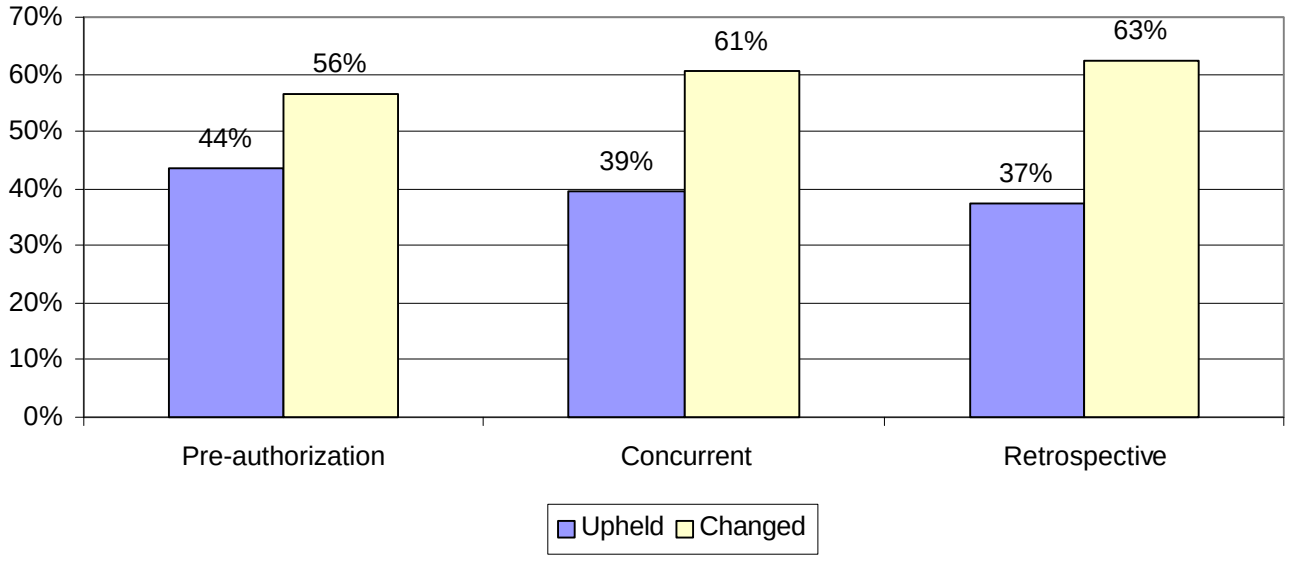
HEAU Appeals and Grievances Cases

Timing of Adverse Decision
FY 2001



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 2001.

Outcomes Based Upon Timing of Adverse Decision
FY 2001

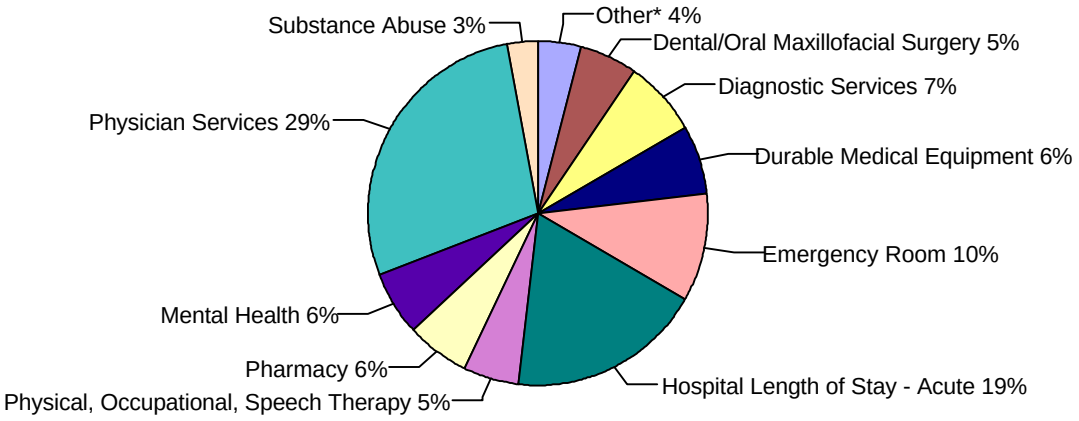


This chart shows the outcomes of Appeals and Grievances Cases mediated by the HEAU during FY 2001. It shows that the outcome of cases vary only slightly based upon when the adverse decision was issued in relationship to the treatment.

HEAU Appeals and Grievances Cases

Type of Service Involved in Cases

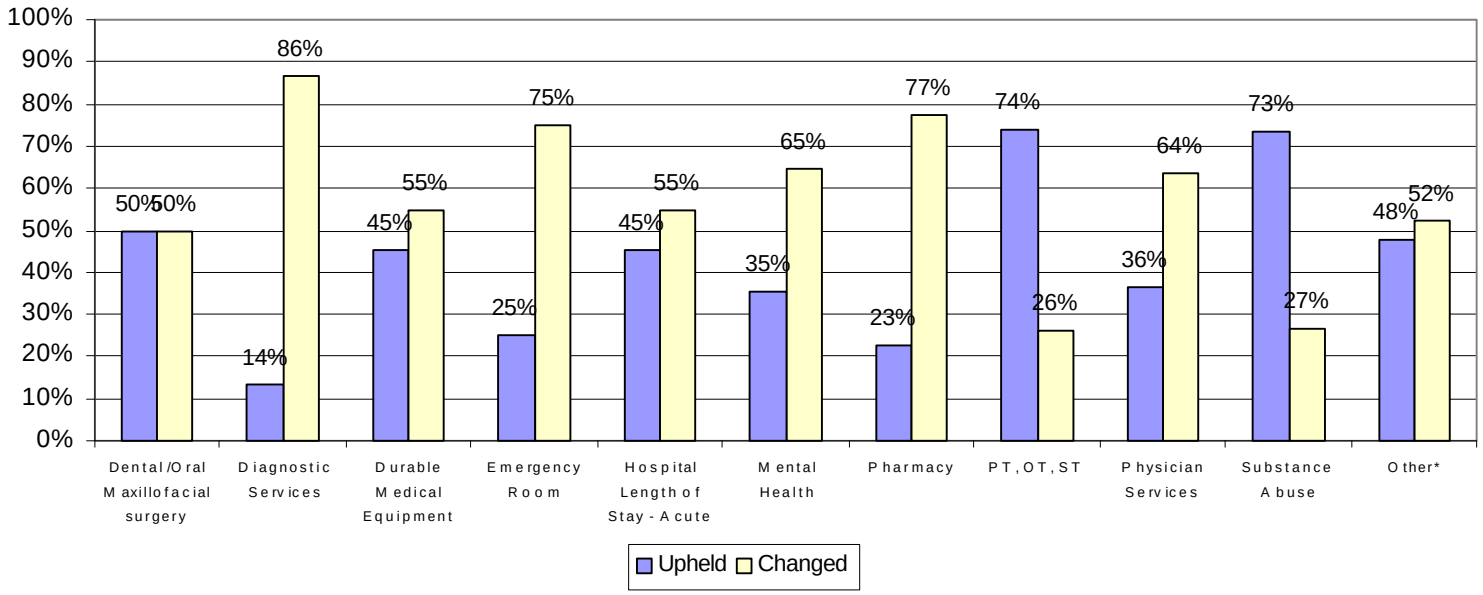
FY 2001



The above chart identifies the types of services involved in Appeals and Grievances cases mediated by the HEAU during FY 2001.

Outcomes of Cases by Type of Service

FY 2001

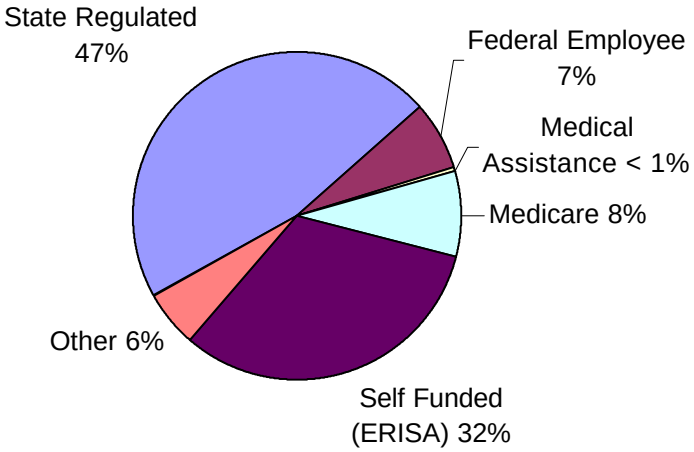


This chart shows the outcomes of Appeals and Grievances cases mediated by the HEAU during FY 2001. It shows how the outcome varies based upon the types of services involved in the cases. Cases resulting in carriers overturning or modifying adverse decisions have been combined for this chart.

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

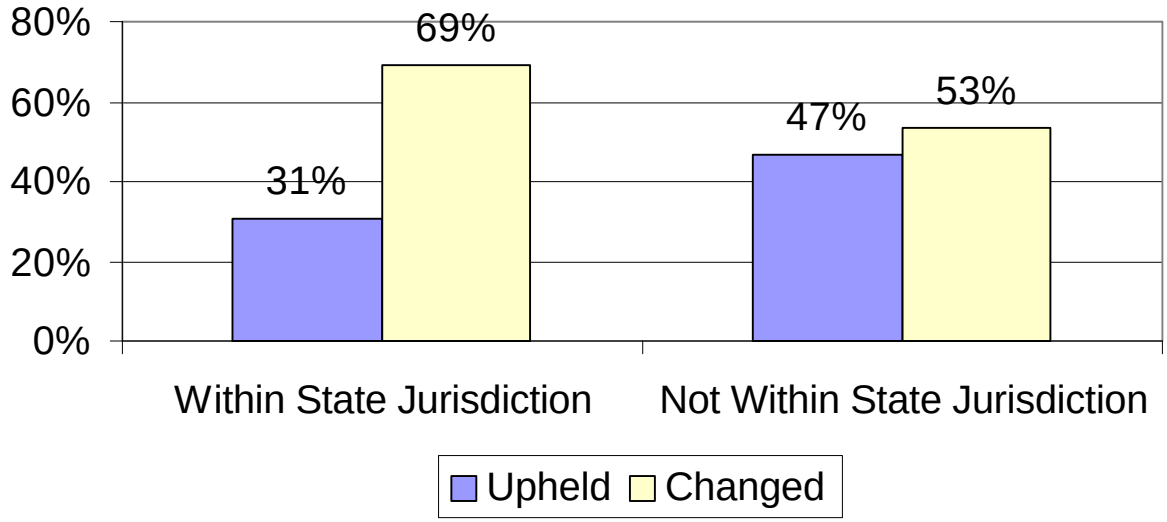
HEAU Appeals and Grievances Cases

Types of Carrier
FY 2001



The above chart identifies the types of carriers involved in the Appeals and Grievances cases mediated by the HEAU during FY 2001.

Outcomes of Cases by Regulatory Authority
FY 2001



This chart shows the outcomes of Appeals and Grievances cases mediated by the HEAU during FY 2001. It shows how the outcome varies based upon whether the carrier is within state jurisdiction*.

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

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September 12, 2001

The Honorable Paul S. Sarbanes
United States Senator
309 Hart Senate Office Building
Washington DC 20510

Dear Senator Sarbanes:

I am writing to let you know that the Patients' Bill of Rights legislation passed this summer by the House of Representatives -- HR 2563 -- may adversely affect programs Maryland has established to help people fight denials of coverage by their HMOs or other health insurance carriers. I understand that the differing versions of the Patients' Bill of Rights passed by the House and Senate will be going to a conference committee, and I am requesting you to do everything in your power to prevent the passage of a federal law that will take away from Marylanders the significant protections established by the Maryland General Assembly's passage of the Maryland Health Insurance Appeals and Grievances Law in 1999.

Since 1999, the Health Education and Advocacy Unit (HEAU) in my office has investigated complaints by more than 2,500 people that they have been improperly denied health care coverage. The HEAU has been successful in getting the HMOs or other insurance carriers to provide or pay for the required health care coverage in 70% of these cases, obtaining payments or services totaling $3.25 million.

When the HEAU is unable to resolve a complaint and the complainant wishes to pursue the matter further, the case is referred to the Maryland Insurance Administration if the insurer is not a self-funded health plan exempt from state regulation under the Employee Retirement Income Security Act (ERISA), Medicare, or Medicaid. The Insurance Administration can conduct an external review of the health plan's decision and, when appropriate, order the plan to pay for the care in question, which it has done in 50% of the cases it has reviewed.

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Overall, the Maryland program has been able to assist 77% of the people denied health care coverage by carriers subject to full state regulation. These Marylanders are very happy to have a state program like ours to turn to when they need assistance getting their HMOs or other insurance carriers to cover their health services. The health plans are generally cooperative with our efforts and have publicly stated their support for this grievance resolution system. A recent report from Maryland's Department and Health and Mental Hygiene showed that patient satisfaction with HMO grievance processes increased dramatically after this law went into effect in 1999. Maryland's General Assembly saw the positive results and in 2000, without serious objection from health plans, expanded the program from its original limited scope that covered only decisions based upon the medical necessity of the service in question so it now covers all types of coverage decisions by health insurers.

It would be bad public policy for a federal law to preempt this program in Maryland or the thirty-nine other states that have similar programs. It could be argued that the language in § Sec. 402 (n)(9) of the Amendment to H.R. 2463 offered by Mr. Norwood of Georgia preempts state programs like Maryland's. To eliminate any such arguments, the intent of Congress should be clearly stated that "Nothing in this Act shall be construed to preclude a state from authorizing state agencies from mediating members' disputes with their health plans and reviewing group health plan's determinations on claims for benefits." Congress should take this opportunity to expressly confirm that Maryland and its sister states may continue their successful efforts to assist their citizens.

We sincerely hope that the House and Senate can work to resolve their differences in the pending legislation and expand the rights of patients. However, we strongly urge you to work toward preserving the laws of Maryland and other states that have already developed and implemented state laws that are serving their citizens well.

Very truly yours,

Joe Curran

Attorney General

JJC/tmd:uscong.ltr