State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

Prepared by:

HEALTH EDUCATION AND ADVOCACY UNIT
CONSUMER PROTECTION DIVISION
OFFICE OF THE ATTORNEY GENERAL

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I. Executive Summary

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

This report covers grievances and complaints filed with or referred during State Fiscal Year 2013, beginning July 1, 2012 and concluding on June 30, 2013.

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

II. Overview of the Appeals and Grievances Process

State Law

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

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

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

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

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

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

decisions" to include a carrier's decision that someone is ineligible for coverage or a carrier's decision that results in the rescission of an individual's coverage. As a result, 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 from coverage. This report, therefore, reflects specific data and statistics for ineligibility denials or rescissions of an individual's coverage.

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

Federal Law

Under the Patient Protection and Affordable Care Act (the "ACA"), consumers have the right to appeal health plans' decisions rendered after March 23, 2010. Through guidance and regulations issued in July 2010[5] and July 2011[6], the U.S. Departments of Health and Human Services ("HHS"), Labor, and 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.

[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).

III. Phases of the Appeals and Grievances Process

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

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

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

[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 member's representative, if any, the right to file appeals and grievances on behalf of patients.

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

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

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

Carrier Statistics FY 2013

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

1. Carriers reported 29,228 adverse decisions in FY 2013, 31,166 fewer adverse decisions than reported in FY 2012; a significant overall reduction. Group Dental Service of Maryland, Inc. reported the largest drop in adverse decisions reporting 18,754 adverse decisions in FY 2012 and only 979 adverse decisions in FY 2013. The HEAU requested information from the MIA about this significant reduction. Group Dental Service of Maryland responded indicating that the change was due to prior reporting by procedure code, which inflated the numbers. According to Group Dental Service, in 2012 it began reporting by claim/request for service rather than at the procedure code level.

2. The carriers administratively reversed 709 of the reported adverse decisions, or less than 3%.

3. In FY 2012, consumers filed 4,712 grievances, a large decrease from the 9,572 grievances filed in FY 2011. In FY 2013, consumers filed only 4,190 internal grievances; a smaller decrease, but a continuing downward trend.

4. Overall, during the internal grievance process carriers altered their original adverse decisions in 52% of the grievances reported in FY 2013. Carriers overturned their adverse decisions in 47.6% of the grievances and modified their determinations in 4.6% of the grievances filed. This represents a decrease in the percentage of grievances carriers altered since FY 2012, when carriers reported changing 59% of their adverse decisions.

5. Outcomes from carriers' internal grievance processes vary significantly based on the type of service in dispute. These trends have remained constant during the past four years, with carriers more often reversing adverse decisions related to physicians and other health care providers than adverse decisions involving mental health care and durable medical equipment. Carriers reduced most between FY 2012 and FY

2013 the percentage of emergency room, inpatient hospital, and laboratory and radiology services they overturned or modified.

6. Adverse decisions involving mental health/substance abuse services continue to be significantly less likely to be overturned or modified than other types of health care services. For FY 2013, carriers reported an overturned or modified rate of only 27% for mental health and substance abuse services. Adverse decisions involving skilled nursing, sub-acute and nursing home facility services are also less likely to be overturned or modified than other types of health care services. For FY 2013, carriers reported an overturned or modified rate of only 20% for these services.

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

[8] While the MIA only conducts the external review for individuals with insured health benefits and the Department of Budget and Management for the State of Maryland 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.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then the MIA will prepare the case for review. As part of the preparation, the MIA will contact the complainant and the carrier in writing, giving them a deadline for submitting additional documentation to be considered in the review as applicable. Once the MIA receives the proper documentation, the case is copied and forwarded to an Independent Review Organization (IRO) for medical necessity reviews. In selecting an IRO, the MIA ensures that the IRO has an appropriate board-certified physician available to review the case. Upon receipt of the case from the MIA, the IRO then transmits the case to 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. The IRO will orally inform the MIA of the expert reviewer's determination and follow up with the written determination via facsimile and first class mail. If the IRO reviewer's recommendation is to overturn, uphold or modify the carrier's denial, the MIA may accept this recommendation and base its final closing letter on the professional judgment of the IRO reviewer. The complainant is notified of the outcome by telephone and/or mail. The MIA also forwards a copy of the IRO's medical opinion and invoice to the carrier via facsimile and U.S. mail. In all instances, the carrier that is the subject of the complaint must pay the expenses of the IRO selected by the MIA. Hearing rights 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 2013

MIA-provided data are reported on the charts and tables contained on pages 19-25 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 747 complaints in FY 2013. After reviewing these complaints, the MIA determined that 363 involved adverse decisions issued by health insurance carriers that the MIA regulated.

2. The MIA referred 61 complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 302 complaints in which complainants challenged the carrier's grievance decision. The MIA modified or reversed the carrier's grievance decision or the carrier reversed its own grievance decision during the course of the MIA's

investigation in 188 cases (62%). Conversely, the MIA upheld 114 (38%) of the carrier decisions.

4. The largest percentage of grievances filed were in the dental care (23%), pharmacy services/formulary issues (17%), physician services (10%), and experimental (10%) categories.

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 HEAU's successful efforts in these areas, the General Assembly selected the HEAU to be the State's first-line consumer assistance agency when it passed the Maryland Appeals and Grievances Law. Since then, other states have used the HEAU as a model when creating their own consumer assistance programs and the HEAU has been cited as a model in Congressional testimony in support of early federal efforts to promote programs that would assist health care consumers, including the Health Care Consumers Assistance Fund Act of 2001. In late 2010, the HEAU received a Consumer Assistance Program grant from the Office of Consumer Information and Insurance Oversight to expand the Unit in anticipation of greater appeal numbers, to provide enrollment assistance to consumers prior to the opening of the Health Insurance Exchanges and to conduct outreach activities about the Unit.

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

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

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

medical and insurance documentation and the HEAU monitors the outcome of the external review.

HEAU Statistics FY 2013

The HEAU Appeals and Grievances data[10] are reported in the charts and tables contained on pages 27-44 of this report. The data reflect both medical necessity and contractual denials. Because newly filed cases contain incomplete data, the cases reported are those cases the HEAU closed during FY 2013.

The HEAU closed 2,108 cases in FY 2013. Of those cases, 769 were appeals and grievances related cases. Not all of the 769 appeals and grievances cases filed with the HEAU were mediated. Some consumers, or other persons, file complaints but an authorization to release medical records form, which the HEAU requires to mediate the case, is never completed. Other complaints are filed for the record only or are referred to another more appropriate agency. Of the 769 appeals and grievances cases the HEAU closed during FY 2013, 581 or 76% involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 581 cases involved more than one carrier.

1. Of the 581 appeals and grievances cases (593 carriers involved) the HEAU mediated during FY 2013, 373 (63%) related to MIA-regulated plans.

2. Of the 581 cases the HEAU mediated during FY 2013, 31% were adverse decision (*medical necessity*) cases, 40% were coverage decision (*contractual exclusion*) cases, and 29% were eligibility denials.

3. The HEAU mediation process resulted in carriers overturning or modifying 55% of the appeals and grievances cases. The carriers overturned or modified 62% of the medical necessity cases, 51% of the coverage decision cases, and 54% of the eligibility denial cases.

4. In cases filed against carriers subject to MIA review, the HEAU mediation efforts resulted in carriers changing their decisions 59% of the time. For non-regulated plans, the HEAU efforts resulted in carriers changing their decisions 48% of the time. There was a noticeable increase in the positive outcomes for consumers in non-regulated plans. In fiscal years 2010, 2011 and 2012, positive outcomes were obtained in 35%, 31% and 39% of the cases respectively. The HEAU attributes the FY 2013 positive increase to the ACA mandated independent external review of medical necessity denials.

5. In FY 2013, the HEAU formally assisted 219 consumers in identifying available health insurance options.

6. In FY 2013, the HEAU assisted patients in recovering or saving more than $2 million dollars, over $1.2 million of which pertained to appeals and grievances cases.

[10] This report does not contain detailed data related to the outcomes of cases handled by HEAU unrelated to the Appeals and Grievances Law; some general complaint numbers and categories are reported for informational purposes. While the HEAU experienced a reduction in Appeals and Grievances cases, the HEAU has seen an increase in call volume (answering over 8,000 calls), more need for education, and a greater complexity in the cases handled.

Appendix

Carrier Cases
Adverse Decisions, Grievances and Outcomes

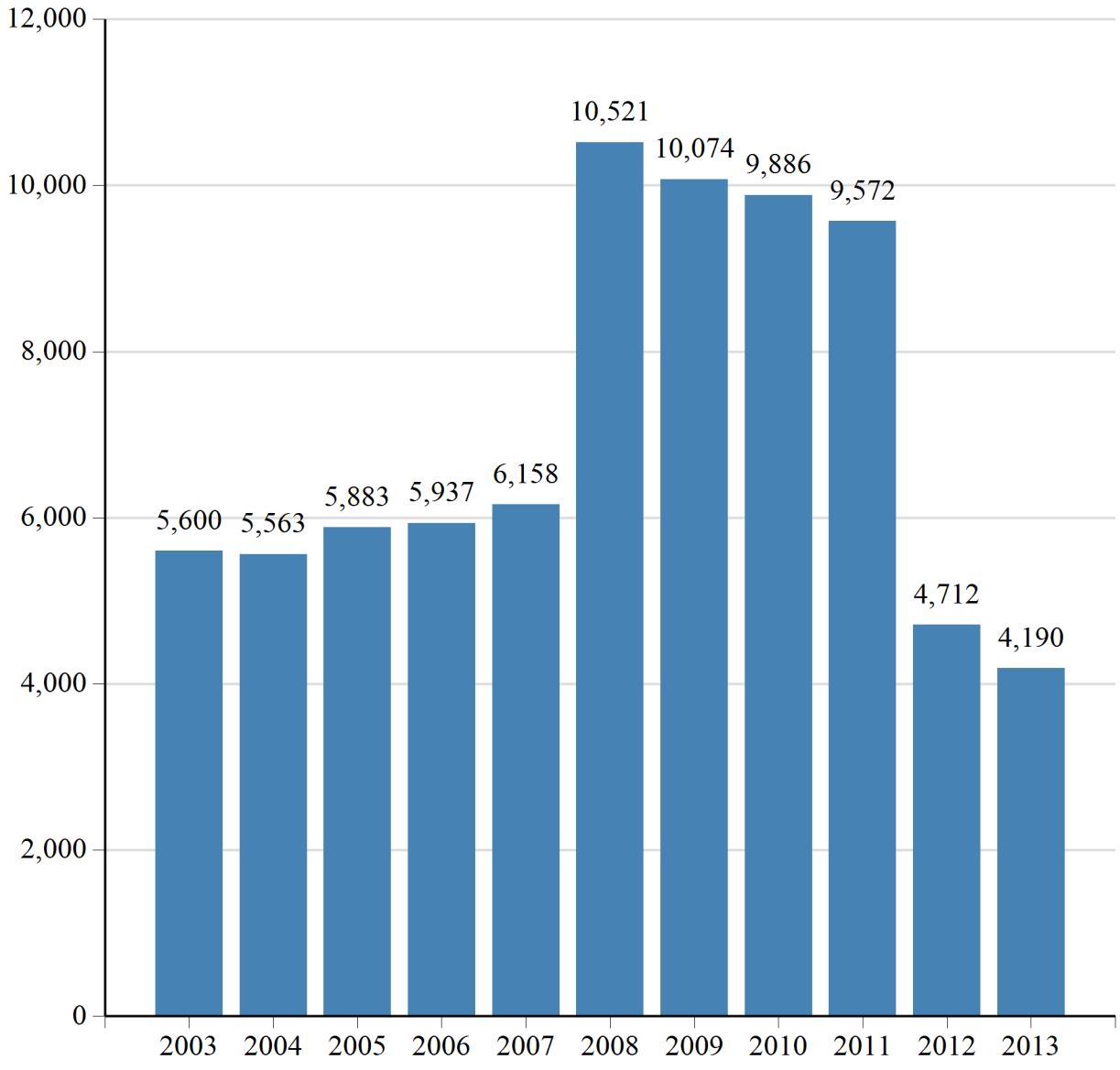
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Aetna Dental Inc.	521	0	0	0%	0%
Aetna Health Inc. (a Pennsylvania corporation)	750	15	70	70%	30%
Aetna Life Insurance Company	706	16	151	62%	38%
Allianz Life Insurance Company of North America	1	0	0	0%	0%
Ameritas Life Insurance Corp.	245	0	36	50%	50%
CareFirst BlueChoice, Inc.	7,794	0	819	32%	68%
Carefirst of Maryland, Inc.	2,372	0	366	29%	71%
Cigna Dental Health of Maryland, Inc.	206	0	3	0%	100%
CIGNA Health and Life Insurance Company	1,350	15	48	58%	42%
Connecticut General Life Insurance Company	991	5	137	58%	42%
Coventry Health Care of Delaware, Inc.	1,483	62	639	74%	26%
Dental Benefit Providers of Illinois, Inc.	32	0	10	40%	60%
Golden Rule Insurance Company	28	1	13	77%	23%
Graphic Arts Benefit Corporation	8	5	5	40%	60%
Group Dental Service of Maryland, Inc.	979	527	74	54%	46%
Group Hospitalization and Medical Services, Inc.	5,887	0	572	38%	62%
Guardian Life Insurance Company of America	625	0	252	38%	62%
HumanaDental Insurance Company	111	0	2	50%	50%
John Alden Life Insurance Company	4	0	0	0%	0%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	659	4	112	69%	31%
Kaiser Permanente Insurance Company	110	0	31	35%	65%
Lincoln Life & Annuity Company of New York	1	0	0	0%	0%
Lincoln National Life Insurance Company	24	0	0	0%	0%
MAMSI Life and Health Insurance Company	70	0	3	0%	100%
MD-Individual Practice Association, Inc.	22	0	131	59%	41%
Metropolitan Life Insurance Company	357	41	7	29%	71%
Nationwide Life Insurance Company	8	1	5	80%	20%
New York Life Insurance Company	3	0	2	100%	0%
Optimum Choice, Inc.	1,080	0	92	46%	54%
Reliance Standard Life Insurance Company	22	0	0	0%	0%
Standard Insurance Company	13	0	6	50%	50%
Standard Security Life Insurance Company of New York	0	0	5	60%	40%
Sun Life Assurance Company of Canada	54	0	5	100%	0%
Time Insurance Company	8	4	1	100%	0%
Union Security Insurance Company	34	13	34	50%	50%
United Concordia Dental Plans, Inc.	1	0	1	100%	0%
United Concordia Life and Health Insurance Company	1,284	0	275	43%	57%
UnitedHealthcare Insurance Company	986	0	207	53%	47%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
UnitedHealthcare of the Mid-Atlantic, Inc.	399	0	76	74%	26%
Total	**29,228**	**709**	**4,190**	**48%**	**52%**

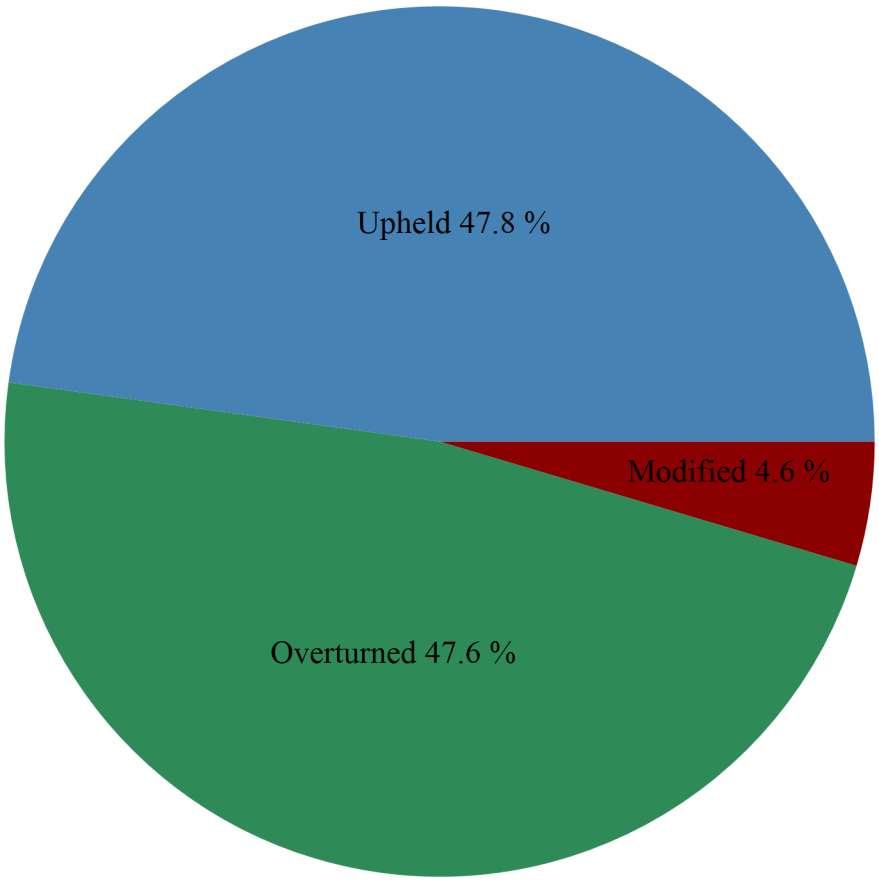
Carrier Grievances Cases
Number of Grievances Since Fiscal Year 2003

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



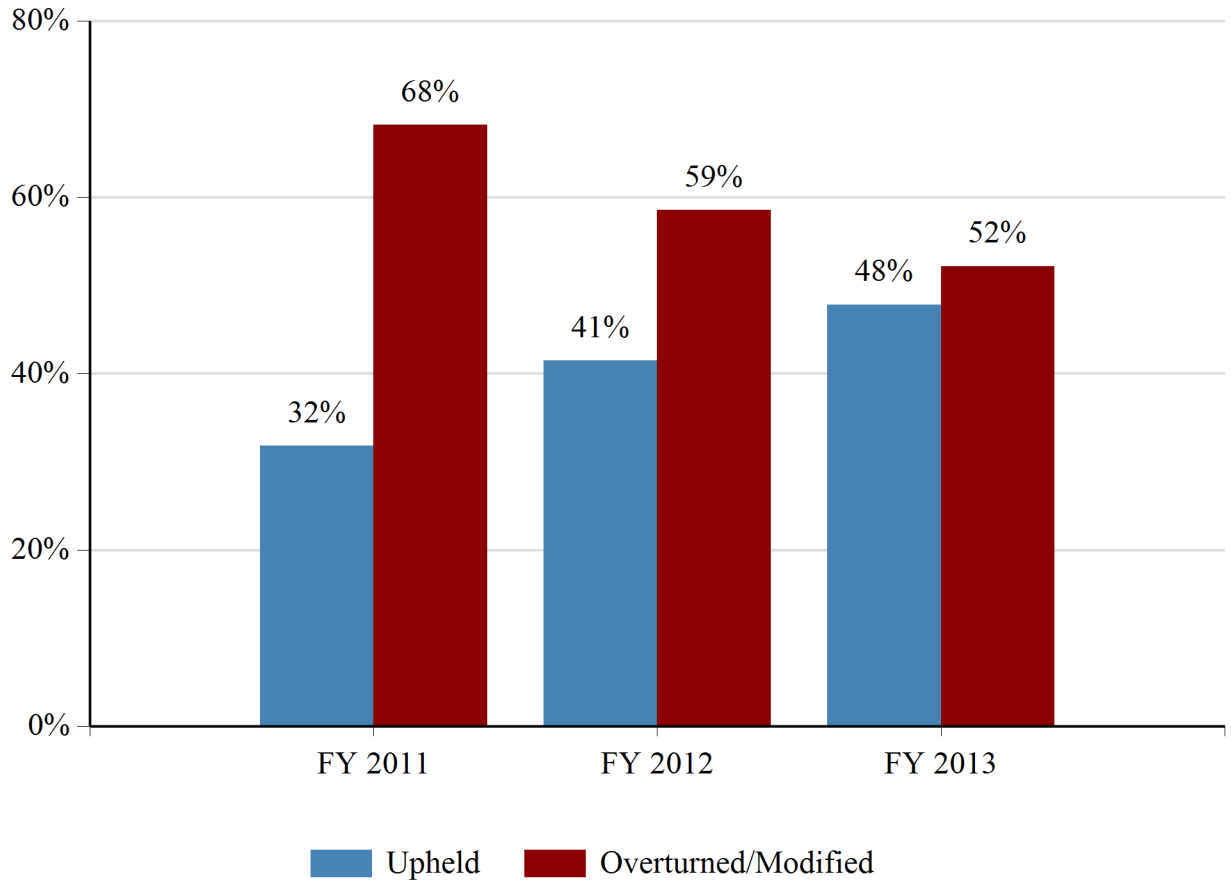
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 4,190 internal grievances filed with carriers in FY 2013, 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 2013, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Durable Medical Equipment	1,633	5.587%	211	5.036%
Emergency Room	327	1.119%	109	2.601%
Home Health	398	1.362%	16	0.382%
Inpatient Hospital	2,141	7.325%	378	9.021%
Laboratory, Radiology	5,503	18.828%	558	13.317%
Mental Health / Substance Abuse	701	2.398%	244	5.823%
Other	209	0.715%	115	2.745%
Pharmacy	3,223	11.027%	442	10.549%
Physician	7,354	25.161%	835	19.928%
Podiatry, Dental, Optometry, Chiropractic	6,495	22.222%	1,127	26.897%
PT, OT, ST	1,175	4.020%	140	3.341%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	69	0.236%	15	0.358%
Total	**29,228**	**100%**	**4,190**	**100%**

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

Carrier Grievances Cases
Outcomes by Service Type

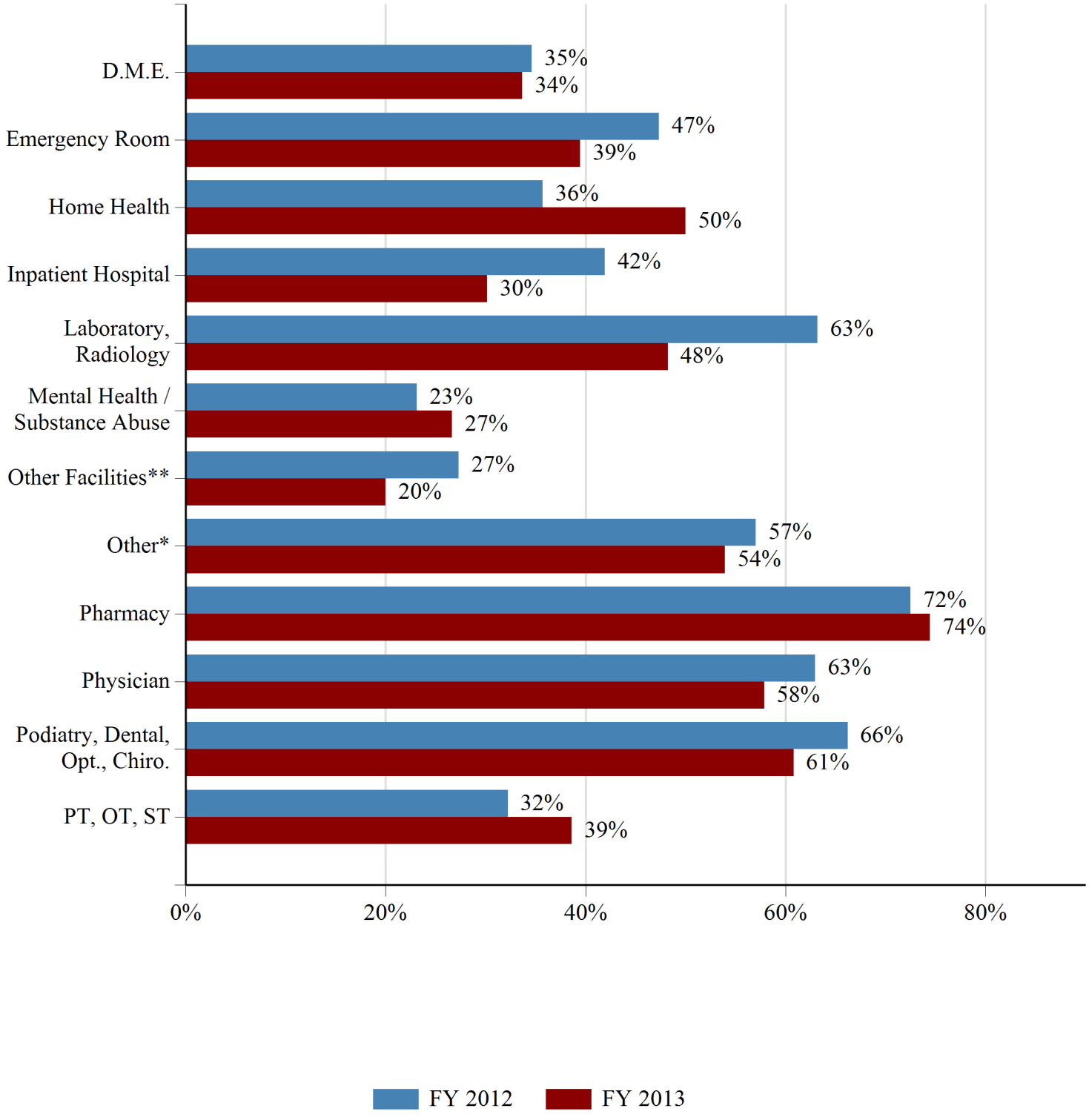
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Durable Medical Equipment	211	66%	34%
Emergency Room	109	61%	39%
Home Health	16	50%	50%
Inpatient Hospital	378	70%	30%
Laboratory, Radiology	558	52%	48%
Mental Health / Substance Abuse	244	73%	27%
Other	115	46%	54%
Pharmacy	442	26%	74%
Physician	835	42%	58%
Podiatry, Dental, Optometry, Chiropractic	1127	39%	61%
PT, OT, ST	140	61%	39%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	15	80%	20%
Total	**4,190**	**48%**	**52%**

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

Carrier Grievances Cases
Two Year Comparison by Service Type

The chart below compares the percentages of grievances carriers overturned or modified by types of services, comparing FY 2012 and FY 2013.

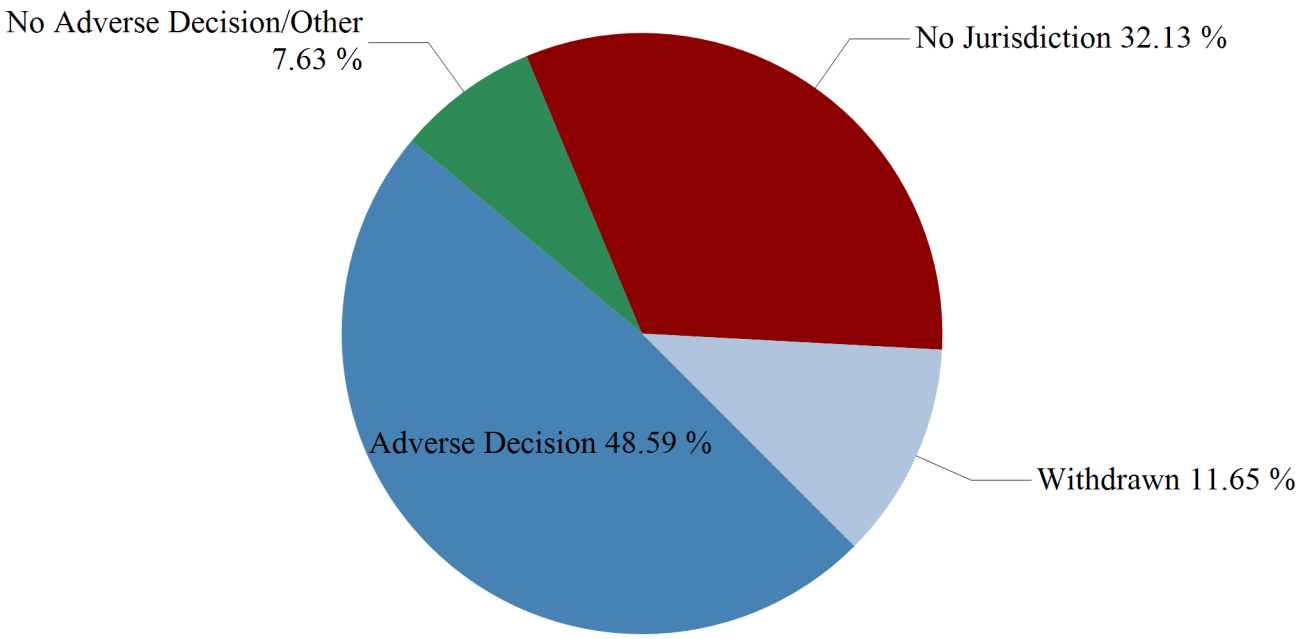


* "Other" means cases where the type of service did not fit an existing category.
** "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.

MIA Appeals and Grievances Complaints
Initial Review of Cases

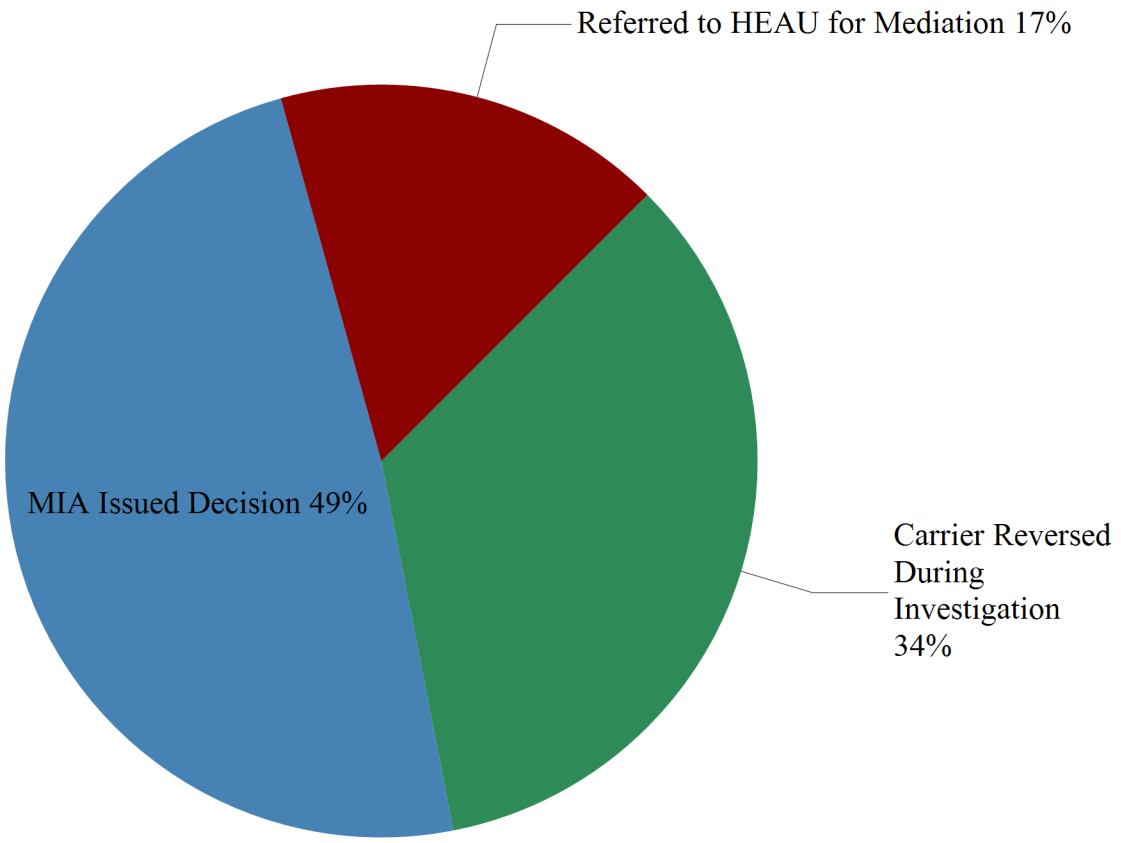
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some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

The chart below details the initial disposition of the 747 cases filed with the MIA's Appeals and Grievances Unit during FY 2013.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2013, the MIA determined that 363 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 61 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 363 grievances the MIA reviewed during FY 2013.



MIA Appeals and Grievances Cases
Carriers and Disposition

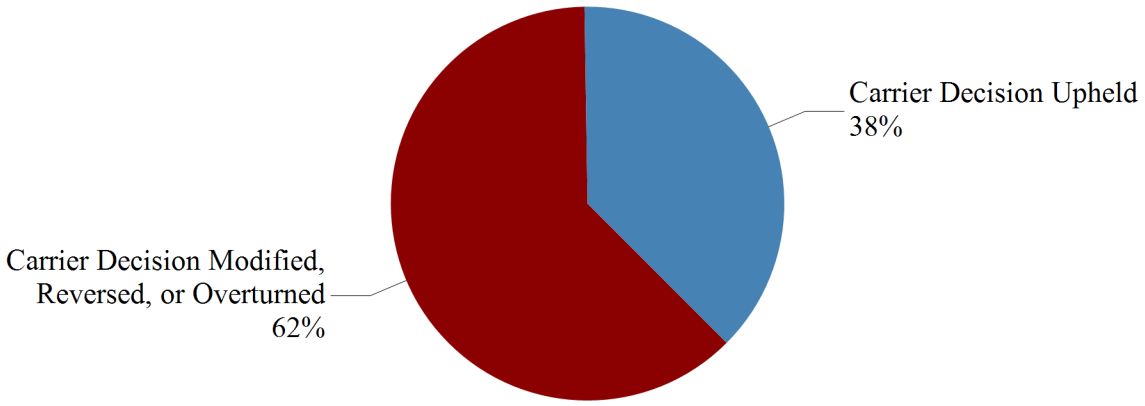
The table below details the outcomes of the 302 grievances complaints the MIA investigated during FY 2013. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health, Inc.	9	2	22.2%	1	11.1%	1	11.1%	5	55.6%
Aetna Life Insurance Company	23	15	65.2%	5	21.7%	0	0.0%	3	13.0%
APS Healthcare	2	0	0.0%	1	50.0%	1	50.0%	0	0.0%
CareFirst BlueChoice, Inc.	49	15	30.6%	8	16.3%	1	2.0%	25	51.0%
Carefirst of Maryland, Inc.	45	21	46.7%	8	17.8%	2	4.4%	14	31.1%
Connecticut General Life Insurance Company	5	3	60.0%	0	0.0%	0	0.0%	2	40.0%
Coventry Health and Life Insurance Company	15	0	0.0%	3	20.0%	1	6.7%	11	73.3%
Coventry Health Care of Delaware, Inc.	7	3	42.9%	0	0.0%	0	0.0%	4	57.1%
Golden Rule Insurance Company	4	2	50.0%	0	0.0%	1	25.0%	1	25.0%
Group Hospitalization and Medical Services, Inc.	37	17	45.9%	7	18.9%	2	5.4%	11	29.7%
Guardian Life Insurance Company of America	7	4	57.1%	1	14.3%	0	0.0%	2	28.6%
HumanaDental Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	8	5	62.5%	0	0.0%	1	12.5%	2	25.0%
MAMSI Life and Health Insurance Company	7	1	14.3%	3	42.9%	0	0.0%	3	42.9%
Maryland Health Insurance Plan	4	1	25.0%	1	25.0%	0	0.0%	2	50.0%
Metropolitan Life Insurance Company	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%

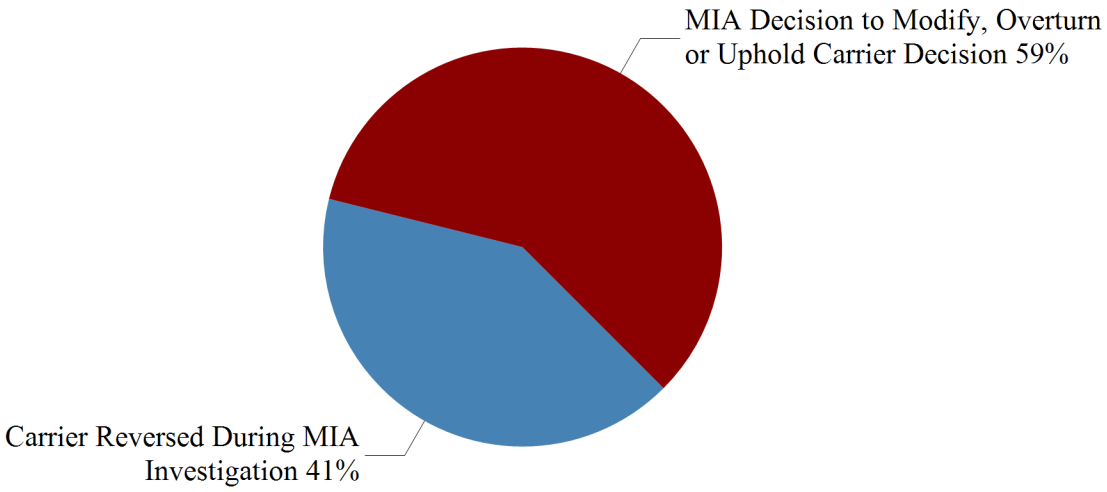
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
National Capital Administrative Services	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Optimum Choice, Inc.	14	4	28.6%	2	14.3%	0	0.0%	8	57.1%
Principal Life Insurance Company	4	2	50.0%	1	25.0%	0	0.0%	1	25.0%
Strategic Resource Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
The Dental Network, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
United Concordia Life and Health Insurance Company	18	3	16.7%	6	33.3%	0	0.0%	9	50.0%
UnitedHealthcare Insurance Company	30	12	40.0%	4	13.3%	1	3.3%	13	43.3%
UnitedHealthcare of the Mid-Atlantic, Inc.	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Services, Inc.	7	2	28.6%	1	14.3%	0	0.0%	4	57.1%
Total	**302**	**114**	**38%**	**52**	**17%**	**11**	**4%**	**125**	**41%**

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 302 grievances the MIA investigated during FY 2013.

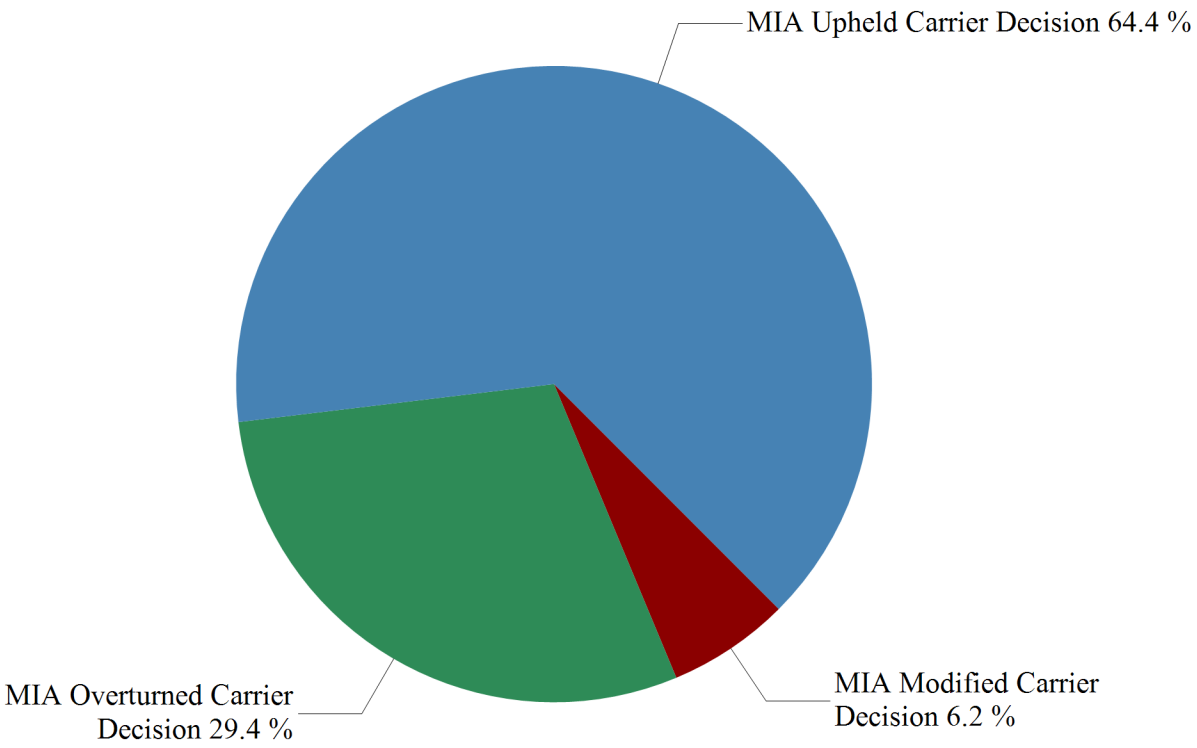


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 177 cases the MIA forwarded to an IRO for review in FY 2013.



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 2013. 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.

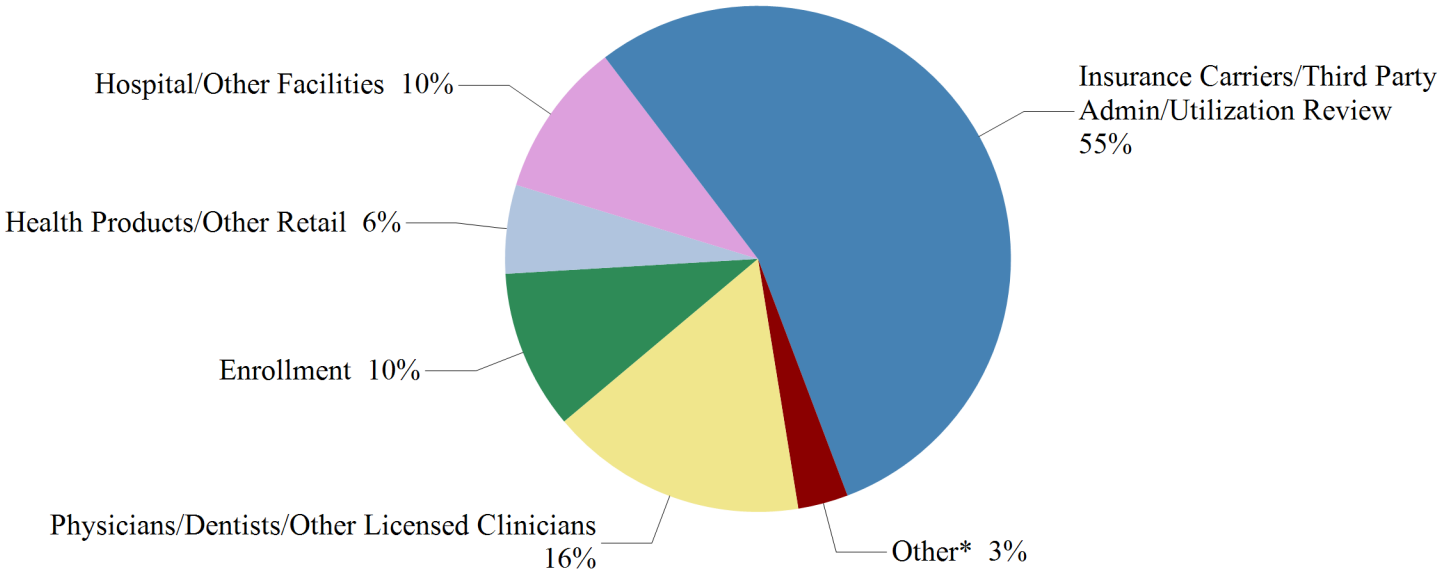
Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Acupuncture	1	0.33%	0	0%	0	0%	0	0%	1	100%
Chiropractic Care Services	2	0.66%	2	100%	0	0%	0	0%	0	0%
Cosmetic	6	1.99%	3	50%	2	33%	0	0%	1	17%
Custodial Care Service	1	0.33%	1	100%	0	0%	0	0%	0	0%
Denial of Hospital Days	12	3.97%	4	33%	3	25%	1	8%	4	33%
Dental Care Services	68	22.52%	26	38%	10	15%	1	1%	31	46%
Durable Medical Equipment	8	2.65%	1	13%	3	38%	0	0%	4	50%
Emergency Room Denial	6	1.99%	1	17%	0	0%	0	0%	5	83%
Emergency Treatment Denial	4	1.32%	0	0%	0	0%	0	0%	4	100%
Experimental	31	10.26%	17	55%	6	19%	0	0%	8	26%
Habilitative Service	2	0.66%	1	50%	1	50%	0	0%	0	0%
Home Care Services	4	1.32%	0	0%	0	0%	2	50%	2	50%
In-Patient Rehabilitation Services	2	0.66%	1	50%	1	50%	0	0%	0	0%
Lab, Imaging, Test Services	16	5.30%	9	56%	1	6%	0	0%	6	38%
Mental Health Partial Hospitalization	3	0.99%	1	33%	0	0%	0	0%	2	67%
Mental Health/Substance Abuse (Inpatient) Services	17	5.63%	6	35%	3	18%	3	18%	5	29%
Mental Health/Substance Abuse (Outpatient) Services	9	2.98%	4	44%	1	11%	2	22%	2	22%
Morbid Obesity	5	1.66%	2	40%	2	40%	0	0%	1	20%
No Preauthorization	1	0.33%	1	100%	0	0%	0	0%	0	0%
Out-of-Network Benefits	3	0.99%	2	67%	0	0%	0	0%	1	33%
Outpatient Services	3	0.99%	1	33%	0	0%	0	0%	2	67%

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Pharmacy Services/Formulary Issues	51	16.89%	15	29%	12	24%	1	2%	23	45%
Physician Services	30	9.93%	10	33%	4	13%	0	0%	16	53%
Preventive or Diagnostic	1	0.33%	0	0%	0	0%	0	0%	1	100%
PT, OT, ST Services	13	4.30%	5	38%	3	23%	0	0%	5	38%
Skilled Nursing Facility Care Services	3	0.99%	1	33%	0	0%	1	33%	1	33%
Total	**302**	**100%**	**114**	**38%**	**52**	**17%**	**11**	**4%**	**125**	**41%**

Percentages may not equal 100% due to rounding.

HEAU Cases
Subject of Complaints

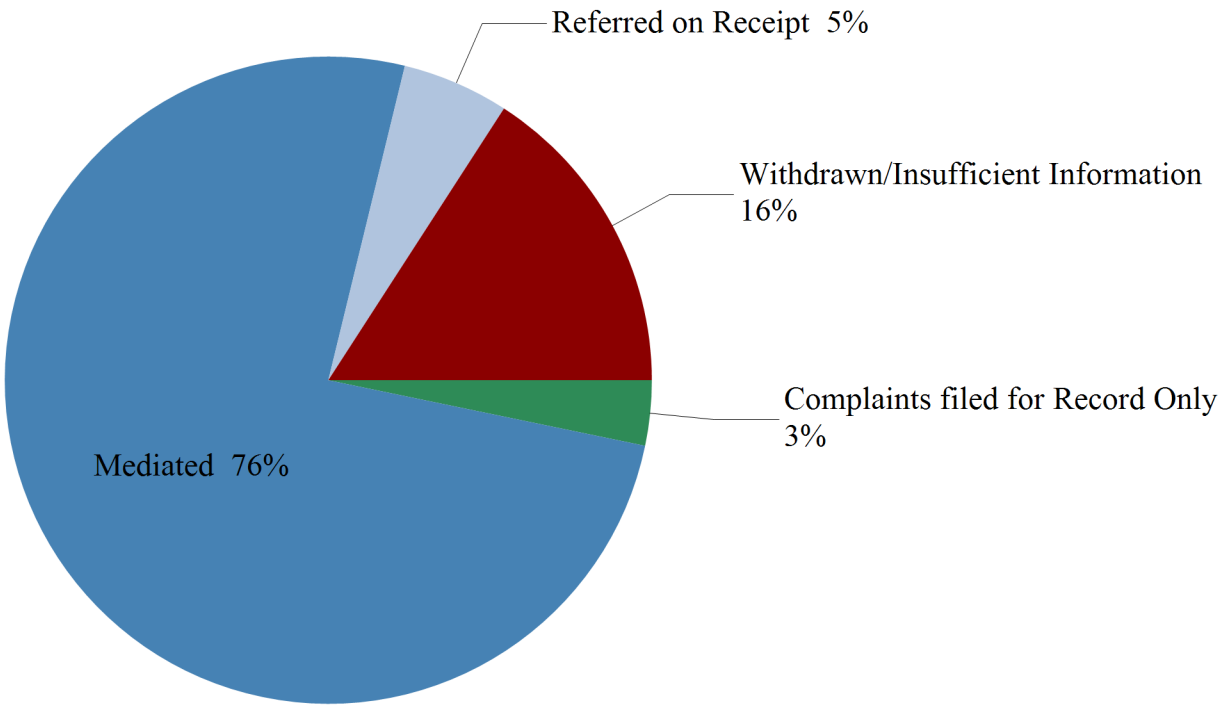
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but the HEAU cases also involve access to medical records, sales and service problems with health care products, and various other issues encountered in the health care marketplace. In FY 2011, the HEAU in accordance with CCIIO grant terms, began collecting data on enrollment assistance cases. These cases are noted as enrollment. The chart below shows the types of industries involved in the cases the HEAU closed during FY 2013. The HEAU closed 2,108 complaints. Some complaints were filed against more than one industry.



* "Other" includes Collection/Billing Entities (.8%), Laboratories (.8%), Ambulance (.5%) and other non-specific categories (e.g. Government Agency).

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 Appeals and Grievances cases closed by the HEAU during FY 2013.



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 2013. Some complaints involve more than one carrier. Accordingly, the total number of complaints is greater than the number of total cases the HEAU mediated and closed in FY 2013.

Carrier	Total Cases	Upheld		Overturned/Modified	
Aetna					
State Regulated	19	10	53%	9	47%
Not State Regulated	29	13	45%	16	55%
Total Complaints	**48**	**23**	**48%**	**25**	**52%**
American Behavioral					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Anthem Blue Cross Blue Shield					
Not State Regulated	3	1	33%	2	67%
Total Complaints	**3**	**1**	**33%**	**2**	**67%**
Anthem Blue Cross of California					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Anthem UM Services Inc					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
APS Healthcare Bethesda, Inc.					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Argus Health Systems, Inc.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Assurant Health					
State Regulated	3	2	67%	1	33%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Blue Cross Blue Shield of Illinois					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield Of Pennsylvania					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Blue Cross Bue Shield of Georgia					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Capital Blue Cross					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Carefirst BlueChoice					
State Regulated	86	29	34%	57	66%
Not State Regulated	7	5	71%	2	29%
Total Complaints	**93**	**34**	**37%**	**59**	**63%**
Carefirst of Maryland					
State Regulated	143	45	31%	98	69%
Not State Regulated	33	14	42%	19	58%
Total Complaints	**176**	**59**	**34%**	**117**	**66%**

CIGNA					
State Regulated	4	2	50%	2	50%
Not State Regulated	23	13	57%	10	43%
Total Complaints	**27**	**15**	**56%**	**12**	**44%**
Coventry Health Care					
State Regulated	6	3	50%	3	50%
Not State Regulated	2	2	100%	0	0%
Total Complaints	**8**	**5**	**63%**	**3**	**38%**
CVS Caremark					
Not State Regulated	4	2	50%	2	50%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**
Delta Dental of California					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Delta Dental of Minnesota					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Delta Dental of Pennsylvania					
Not State Regulated	3	3	100%	0	0%
Total Complaints	**3**	**3**	**100%**	**0**	**0%**
Delta Dental of Virginia					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Denex Dental					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Dental Benefit Providers, Inc.					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Empire BlueCross BlueShield					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Express Scripts					
State Regulated	2	0	0%	2	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
FELRA & UFCW Health and Welfare Fund					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
GEHA					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Golden Rule Insurance					
State Regulated	6	4	67%	2	33%
Not State Regulated	12	8	67%	4	33%
Total Complaints	**18**	**12**	**67%**	**6**	**33%**
Group Dental Service of Maryland					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**

Guardian Life Insurance Company of America					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
InforMed, LLC					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Johns Hopkins Employer Health Programs					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	32	24	75%	8	25%
Not State Regulated	5	3	60%	2	40%
Total Complaints	**37**	**27**	**73%**	**10**	**27%**
Magellan Behavioral Health					
State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Maryland Health Insurance Plan (MHIP)					
State Regulated	11	4	36%	7	64%
Total Complaints	**11**	**4**	**36%**	**7**	**64%**
MDIPA					
Not State Regulated	3	2	67%	1	33%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Medco Health Solutions, Inc.					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**

Medicare					
Not State Regulated	5	2	40%	3	60%
Total Complaints	**5**	**2**	**40%**	**3**	**60%**
Medicare Advantage					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
MedSolutions					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Metropolitan Life Insurance Company					
State Regulated	4	2	50%	2	50%
Not State Regulated	2	2	100%	0	0%
Total Complaints	**6**	**4**	**67%**	**2**	**33%**
Mutual of Omaha					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
National Claims Administrative Services					
Not State Regulated	10	4	40%	6	60%
Total Complaints	**10**	**4**	**40%**	**6**	**60%**
Optimum Choice					
State Regulated	4	2	50%	2	50%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**
Premera Blue Cross					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

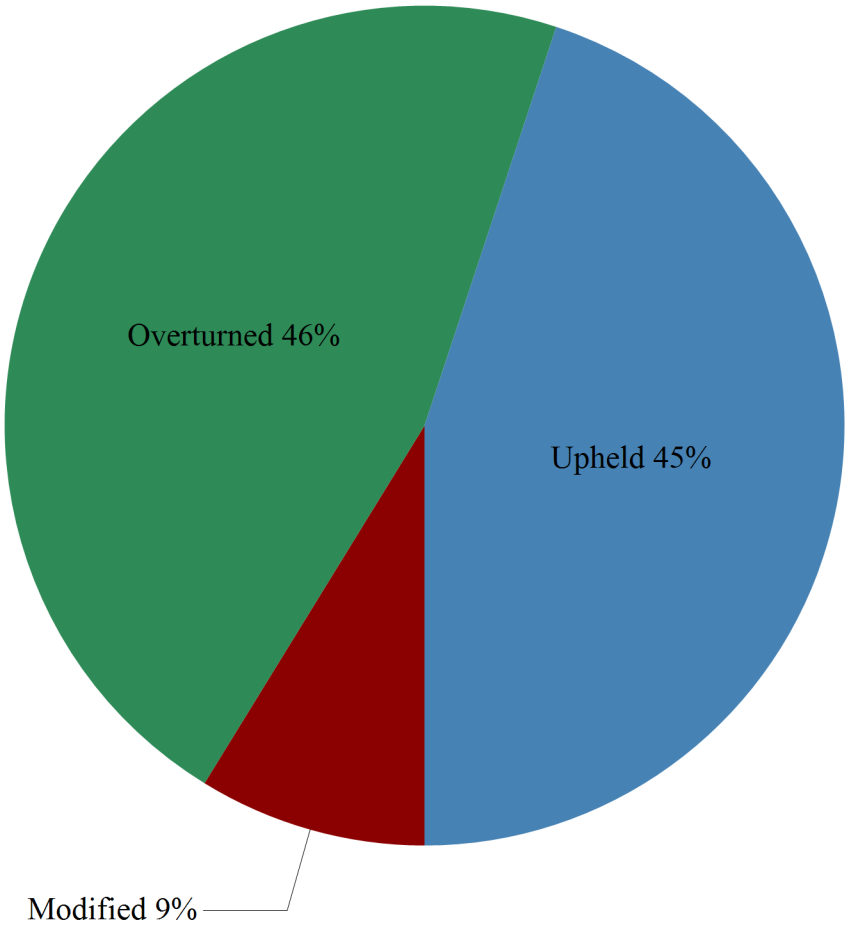
Principal Financial Group					
State Regulated	2	1	50%	1	50%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Seven Corners, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
State Farm Insurance Companies					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Tricare					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
UMR					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
United Behavioral Health					
State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
United Concordia Companies, Inc.					
State Regulated	16	8	50%	8	50%
Not State Regulated	7	5	71%	2	29%
Total Complaints	**23**	**13**	**57%**	**10**	**43%**

United Healthcare					
State Regulated	25	8	32%	17	68%
Not State Regulated	32	16	50%	16	50%
Total Complaints	**57**	**24**	**42%**	**33**	**58%**
US Family Health Plan - Johns Hopkins Medical Service Corp.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Value Options					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
WEB-TPA					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Totals					
State Regulated	373	153	41.0%	220	59.0%
Not State Regulated	220	114	51.8%	106	48.2%
TOTALS	**593**	**267**	**45%**	**326**	**55%**

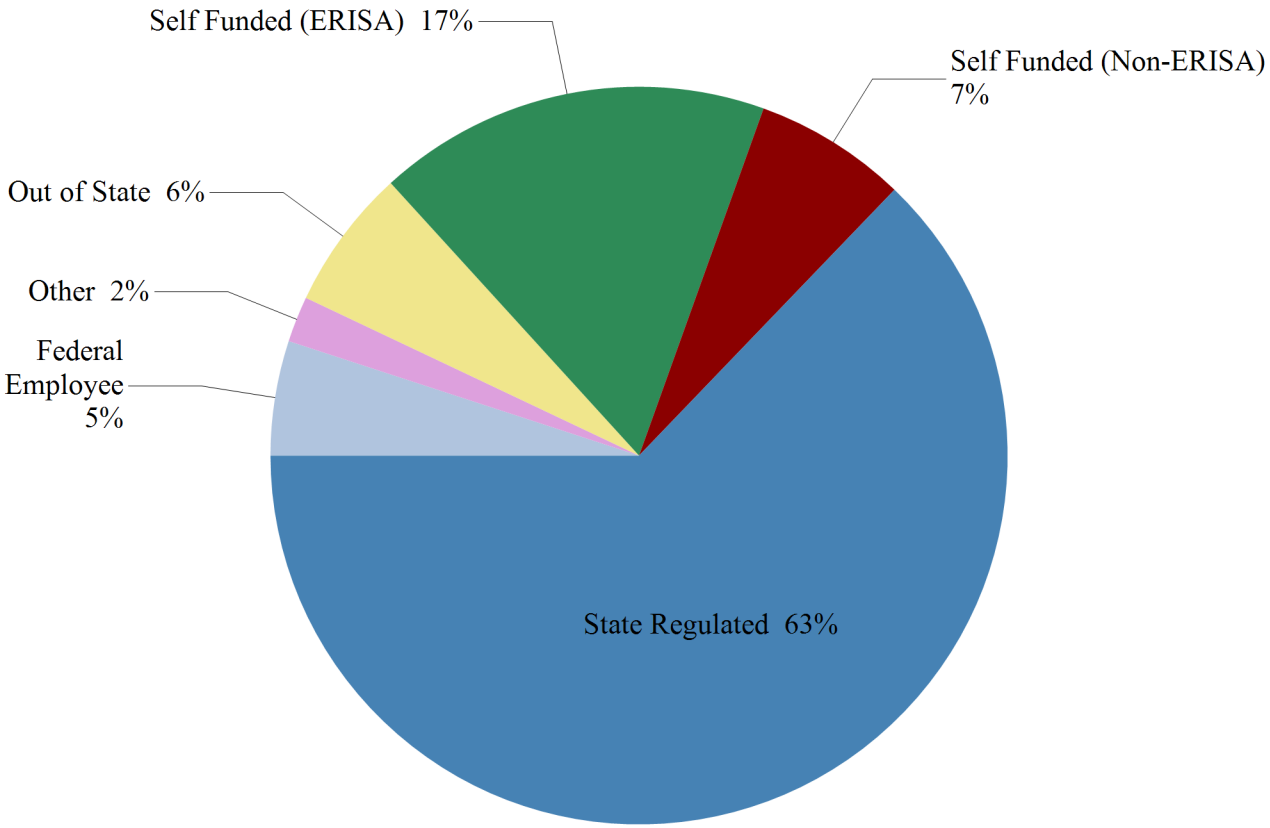
HEAU Mediated Appeals and Grievances Cases
Disposition

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 2013.



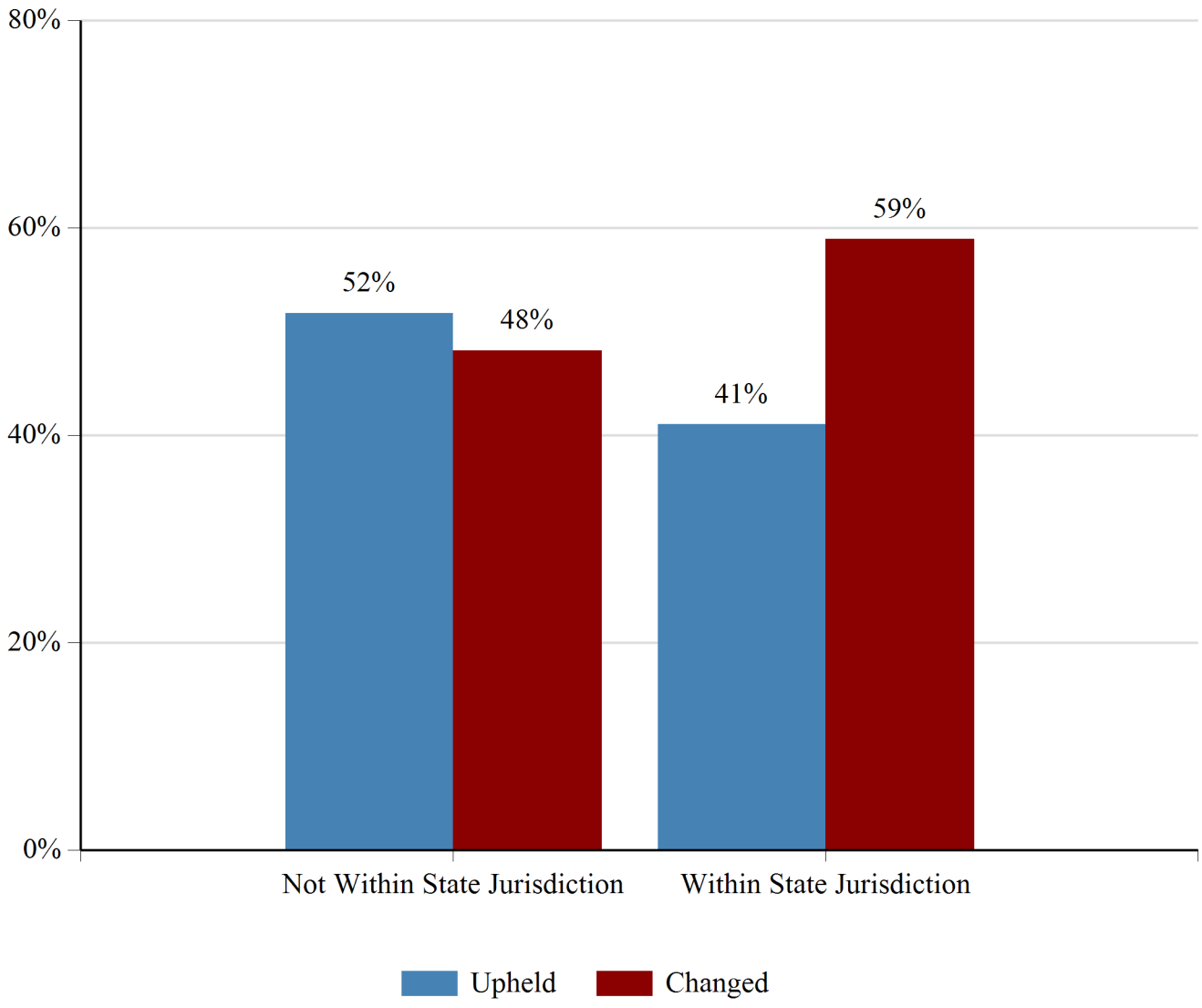
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the types of carriers involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2013.



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

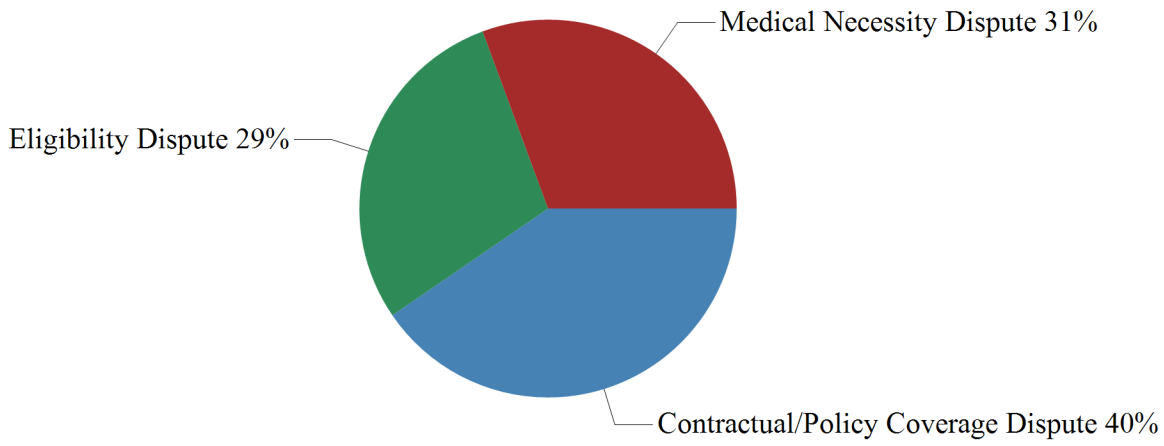
The chart below reflects the outcomes of Appeals and Grievances cases the HEAU mediated and closed during FY 2013 in relation to the MIA's regulatory authority over the carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

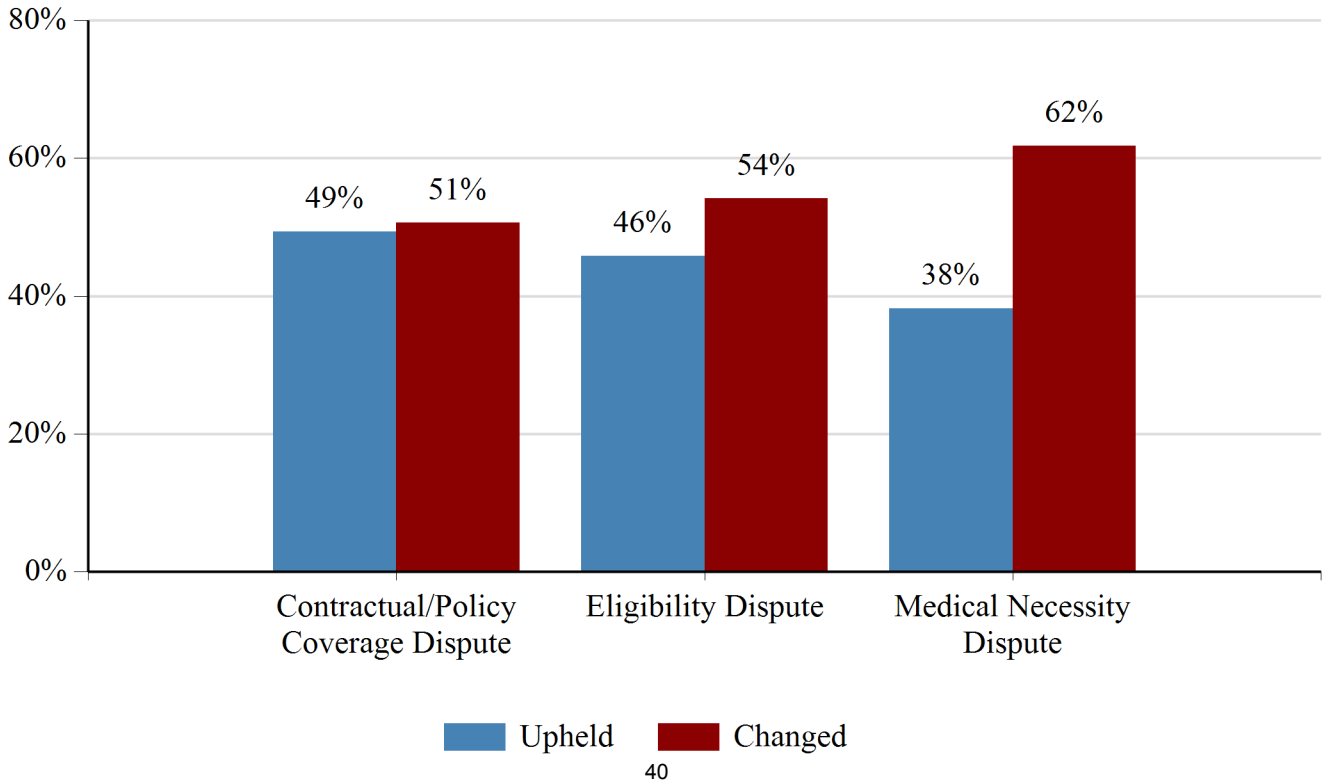
Types of Denials

The HEAU reports data on medical necessity, contractual coverage and eligibility disputes. The chart below identifies the percentages of each type of case the HEAU mediated and closed during FY 2013.



Outcomes by Denial Type

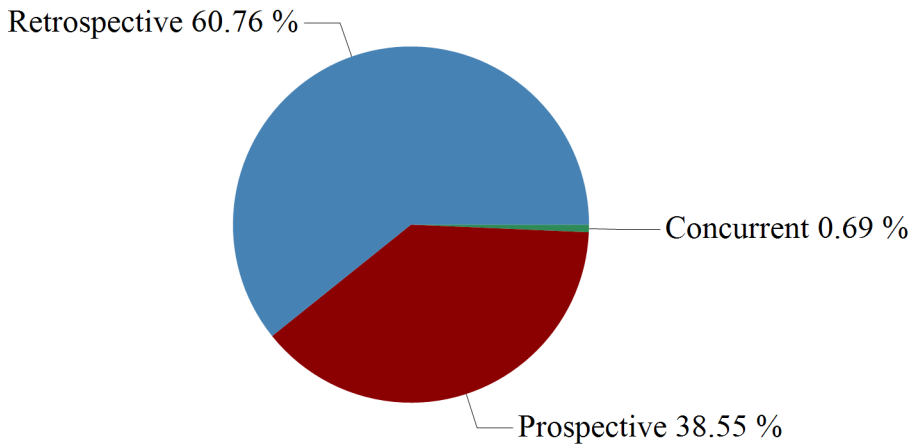
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes that the HEAU mediated and closed during FY 2013.



HEAU Mediated Appeals and Grievances Cases

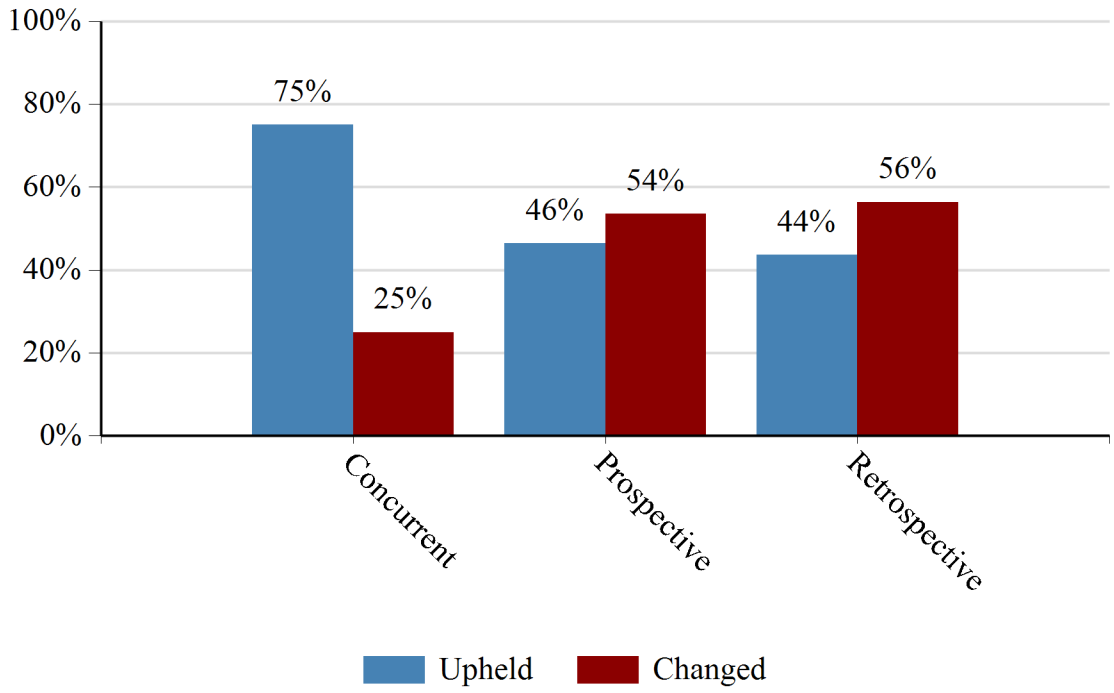
Timing of Denials

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 2013. Eligibility denials are treated as prospective denials.



Outcomes by Timing of Denials

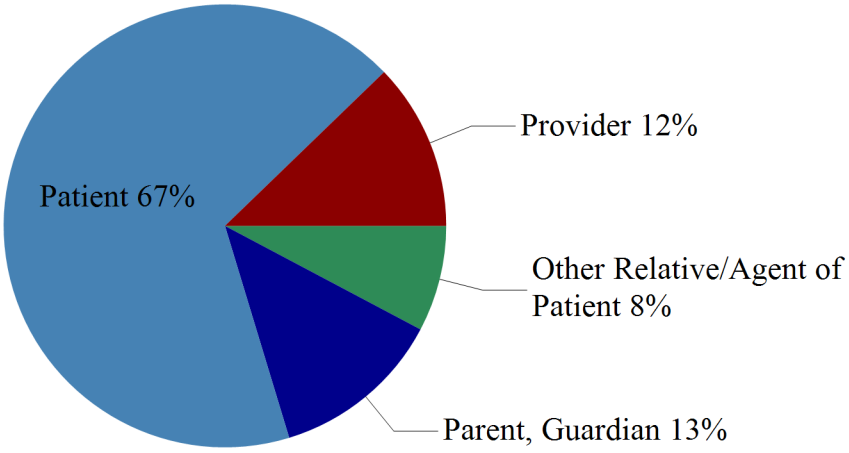
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2013 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

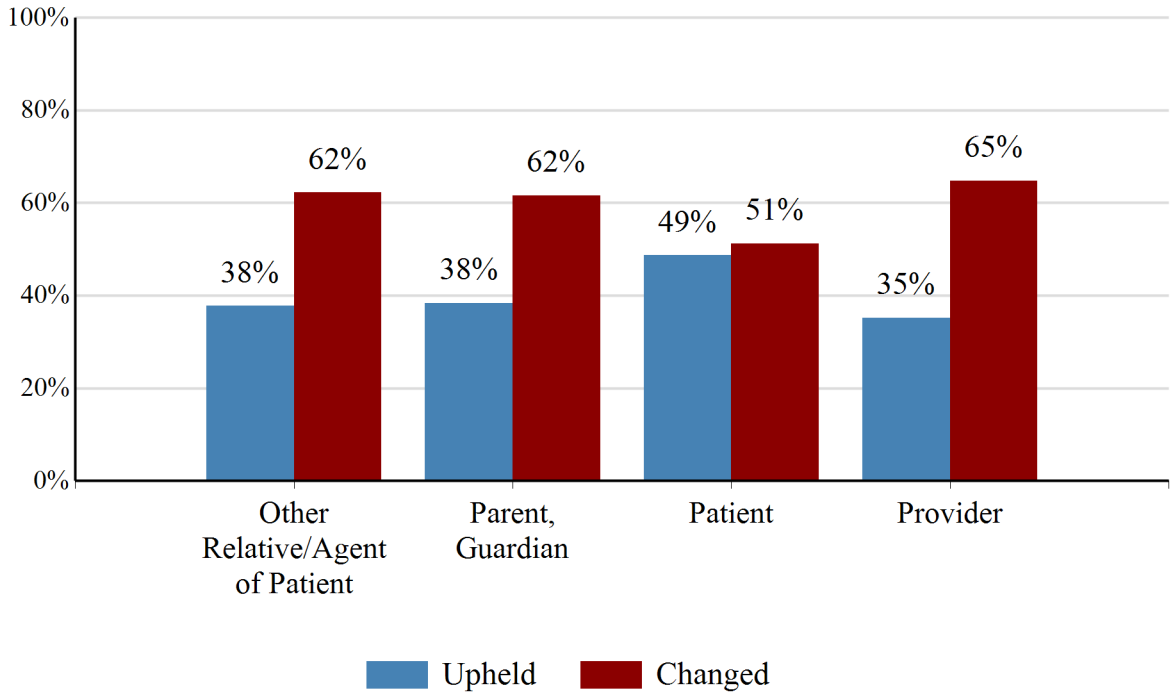
Who Filed the Case

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 2013.



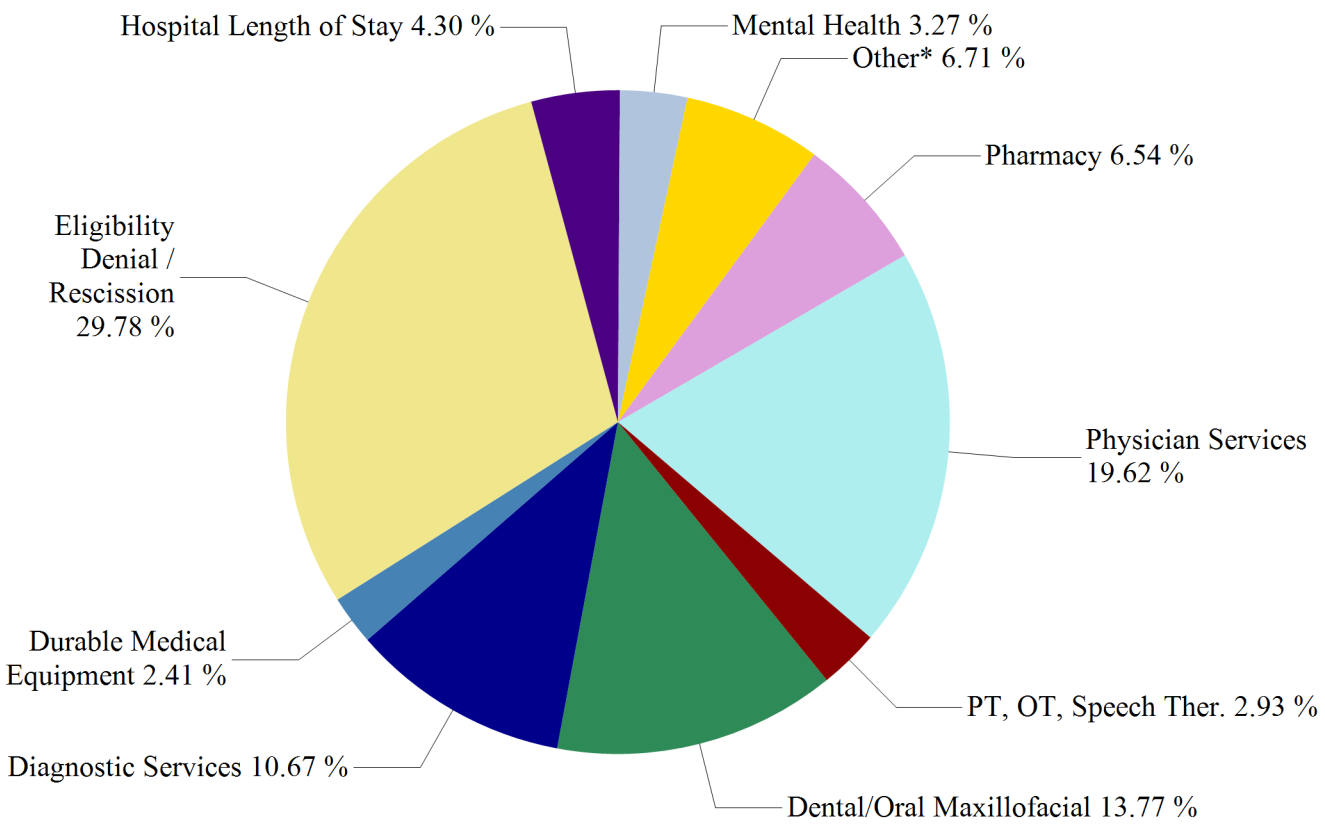
Outcomes by Who Filed the Case

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 2013.



HEAU Mediated Appeals and Grievances Cases
Types of Services Denied

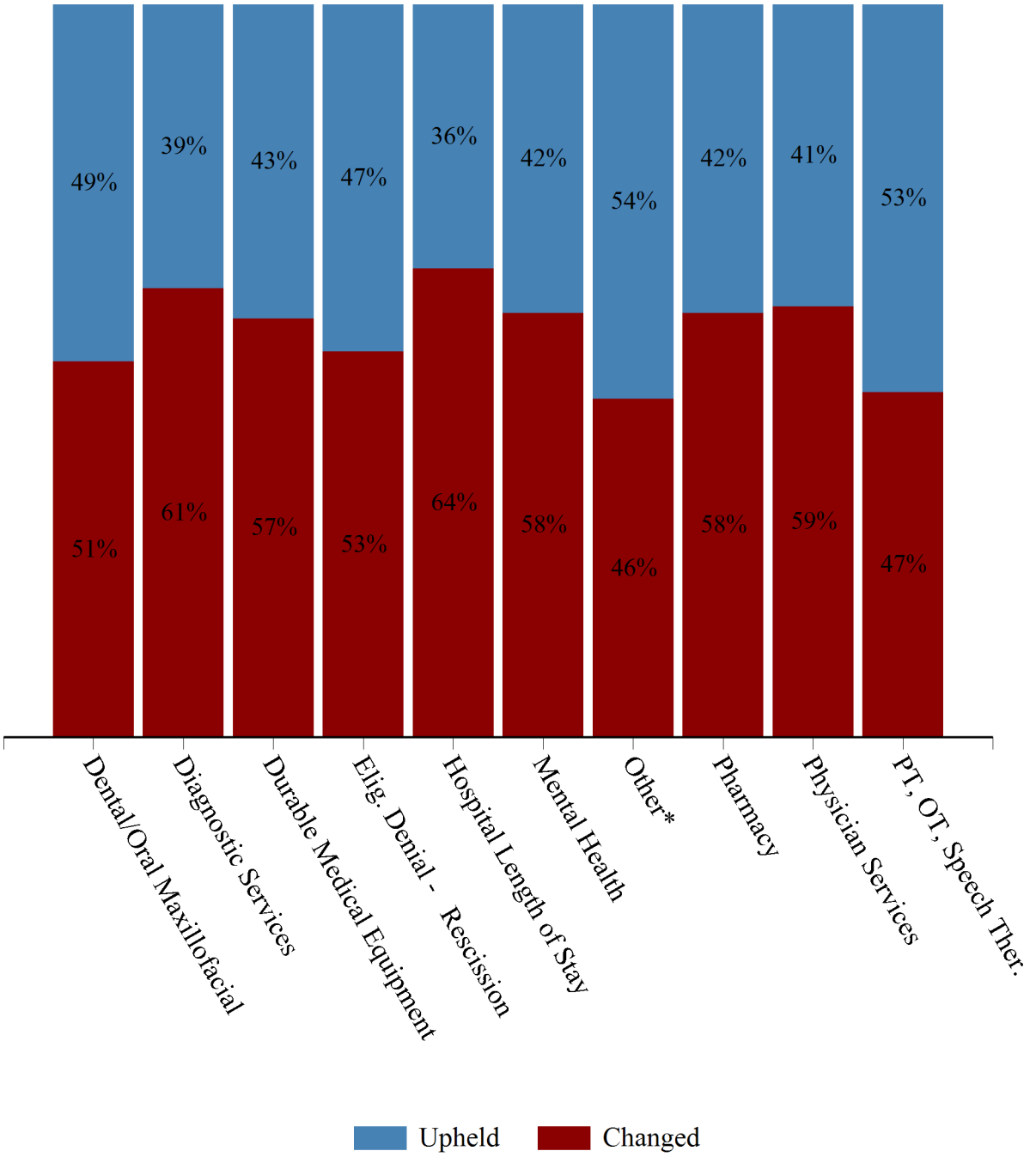
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2013.



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

HEAU Mediated Appeals and Grievances Cases
Outcomes by Service Type

The chart below compares the outcomes of the Appeals and Grievances cases the HEAU mediated and closed during FY 2013 based on the type of services denied.



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