



State of Maryland  
OFFICE OF THE ATTORNEY GENERAL

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ANNUAL REPORT ON THE  
HEALTH INSURANCE CARRIER  
APPEALS AND GRIEVANCES PROCESS

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

Submitted to the Governor and General Assembly

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## TABLE OF CONTENTS

<b>Executive Summary</b> .....	1
Overview of the Appeals and Grievances Process .....	1
STATE LAW .....	1
FEDERAL LAW .....	2
Phases of the Appeals and Grievances Process .....	2
Carrier Reporting .....	3
CARRIER STATISTICS FY 2014.....	4
Maryland Insurance Administration .....	5
MIA STATISTICS FY 2014 .....	6
Health Education and Advocacy Unit.....	6
HEAU STATISTICS FY 2014.....	8
<b>Appendix</b> .....	10
<b>CARRIER GRIEVANCES CASES</b>	
Adverse Decisions, Grievances and Outcomes .....	11
Number of Grievances Since 2004 .....	14
Outcomes .....	15
Three Year Comparison of Outcomes .....	16
Types of Services.....	17
Outcomes by Service Type.....	18
Two Year Comparison by Service Type.....	19
<b>MIA APPEALS AND GRIEVANCES CASES</b>	
Initial Review of Complaints.....	20
Initial Disposition of Grievances .....	21
Carriers and Disposition .....	22
Disposition Following Investigation.....	24
Disposition Resulting from IRO Review.....	25
Types of Services Denied and Outcomes .....	26
<b>HEAU CASES: SUBJECT OF COMPLAINTS</b> .....	28
<b>HEAU APPEALS AND GRIEVANCES CASES: INITIAL DISPOSITION OF COMPLAINTS</b> .....	29
<b>HEAU MEDIATED APPEALS AND GRIEVANCES CASES</b>	
Carriers, Regulatory Authority and Disposition.....	30
Disposition .....	39
Types of Carriers.....	40
Outcomes Based on MIA Regulatory Authority .....	41
Types of Denials .....	42
Outcomes by Denial Type .....	42

Timing of Denials .....	43
Outcomes By Timing of Denial.....	43
Who Filed the Case.....	44
Outcomes by Who Filed the Case.....	44
Types of Services Denied .....	45
Outcomes by Service Type.....	46

## 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<sup>1</sup> (the “Appeals and Grievances Law”) as required by the Maryland Insurance Article §15-10A-08 and the Maryland Commercial Law Article §13-4A-04. Section 15-10A-08(b)(1) of the Maryland Insurance Article requires the HEAU to annually publish a summary report on the grievances and complaints filed with or referred to a carrier, the Commissioner of the Maryland Insurance Administration (the “MIA”), the HEAU, or any other federal or State government agency or unit during the previous fiscal year. Section 15-10A-08(b)(2) of the Maryland Insurance Article also requires the HEAU to evaluate the effectiveness of the internal grievance process and complaint process available to members, and to include in its annual summary report the results of this evaluation and any proposed changes that the HEAU considers necessary.

This report covers grievances and complaints filed or referred during State Fiscal Year 2014, beginning July 1, 2013 and concluding on June 30, 2014.

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’<sup>2</sup> 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<sup>3</sup> 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,<sup>4</sup> each of which expanded the definition of “coverage decisions” to include a carrier’s decision that someone is ineligible for coverage or a carrier’s

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<sup>1</sup> Md. Code Ann., Insurance §15-10A-01 through §15-10A-10.

<sup>2</sup> 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.

<sup>3</sup> Md. Code Ann., Insurance §15-10D-01 through §15-10D-04.

<sup>4</sup> Chapters 3 and 4 made other changes to processes and rights under the Appeals and Grievances Law that became effective July 1, 2011.

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<sup>5</sup> and July 2011<sup>6</sup>, the U.S. Departments of Health and Human Services ("HHS"), Labor, and Treasury standardized internal claims and appeals and external review processes for group health insurance plans and health insurance issuers offering coverage in the group and individual markets. Under the regulations, consumers have the right to:

1. information about why a claim or coverage has been denied and how they can appeal that decision;
2. appeal to the insurance company to conduct a full and fair review of its decision (*internal appeals*); and
3. take their appeals to an independent third-party review organization ("IRO") for review of the insurer's decision (*external review*) for claims that involve (a) medical judgment (including but not limited to those based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer, or (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

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

### III. Phases of the Appeals and Grievances Process

For both adverse decisions and coverage decisions, the appeals and grievances process starts when a patient receives notice from the carrier that the carrier has rendered an adverse decision or coverage decision. Carriers must provide patients with a written notice that clearly

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<sup>5</sup> 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 23, 2010).

<sup>6</sup> 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 26, 2011).

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

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

#### IV. Carrier Reporting

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

- The carriers are only required to report information on medical necessity denials (*adverse decisions*). Accordingly, the State does not collect comprehensive information about the types and outcomes of contractual exclusions of health care services (*coverage decisions*) rendered by the carriers.
- The carriers do not report data about each individual grievance. The carriers divide their data into medical service categories and report on the limited data within each category. As the categories are not standardized, reporting and categorizing may vary significantly from one carrier to another, making it difficult to compare one carrier's data to that of another.
- The diagnosis and procedure information carriers report is incomplete. Carriers must report diagnostic or treatment codes for a limited number of complaints. Although the limited data provide basic evaluative information, complete reporting would provide a more valuable tool in analyzing grievance data.

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<sup>7</sup> 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 patients' representative, if any, the right to file appeals and grievances on behalf of patients.

- Carriers are not required to identify the grievances that involved the MIA or the HEAU. As this information is not present, it is impossible to check the cases reported by carriers against the data recorded by the MIA or the HEAU to verify the consistency of data reporting.
- An analysis of the number of adverse decisions and grievances compared to enrollee numbers cannot be performed as carriers are not required to report membership or enrollee numbers.

#### *Carrier Statistics FY 2014*

In addition to the highlights below, charts providing statistical detail from the data submitted by the carriers appear on pages 11-19 of this report.

1. Carriers reported 32,512 adverse decisions in FY 2014, 3,284 more adverse decisions than reported in FY 2013. CIGNA Health and Life Insurance Company reported the largest increase in adverse decisions, reporting 1,350 adverse decisions in FY 2013 and 4,717 adverse decisions in FY 2014.
2. The carriers administratively reversed 881 of the reported adverse decisions, or less than 3%.
3. In FY 2014, consumers filed 4,870 grievances, an increase over the 4,190 grievances filed in FY 2013. This increase stopped the previously noted downward trend in number of grievances filed in prior reporting years.
4. Overall, during the internal grievance process carriers altered their original adverse decisions in 47% of the grievances reported in FY 2014. Carriers overturned their adverse decisions in 42% of the grievances and modified their determinations in 5% of the grievances filed. This represents a decrease in the percentage of grievances carriers altered since FY 2013, when carriers reported changing 52% of their adverse decisions.
5. Outcomes from carriers' internal grievance processes vary significantly based on the type of service in dispute. Over the past four years carriers were more likely to reverse their adverse decisions in cases involving physician treatment and other health care provider treatment, and less likely to reverse their decisions in cases involving mental health care and durable medical equipment. This year there was a decrease in the percentage of adverse decisions reversed for physicians, from 58% in FY 2013 to 40% in FY 2014; however, cases involving mental health care and durable medical equipment continued to be less likely to be overturned.
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. In FY 2014, carriers reported an overturned or modified rate of only 31% for mental health and substance abuse services. In FY 2014, carriers had low reversal rates for home health and inpatient hospital stays; reporting an overturned or modified rate of only 21% for home health services and 25% for inpatient hospital stays.

## 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.<sup>8</sup>

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.

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

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

the IRO 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 2014*

MIA-provided data are reported on the charts and tables contained on pages 20-27 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 844 complaints in FY 2014. After reviewing these complaints, the MIA determined that 419 involved adverse decisions issued by health insurance carriers that the MIA regulated.
2. The MIA referred 60 complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.
3. The MIA investigated 359 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 207 cases (58%). Conversely, the MIA upheld 152 (42%) of the carrier decisions.
4. Like FY 2013, the largest percentages of grievances filed were in the dental care (18%), pharmacy services/formulary issues (17%), experimental (17%) and physician services (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 HEAU received additional grant funding which requires the Unit to help consumers resolve problems enrolling on the Exchange and with obtaining premium tax credits and cost-sharing reductions.

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

When the HEAU receives a request for assistance, the HEAU gathers basic information from the carriers related to the services or care denied. Specifically, the HEAU asks the carrier to provide a copy of the insurance contract provisions 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 2014*

The HEAU Appeals and Grievances data<sup>9</sup> are reported in the charts and tables contained on pages 28-46 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 2014.

The HEAU closed 1,864 cases in FY 2014. Of those cases, 601 were appeals and grievances related cases. Not all of the 601 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 601 appeals and grievances cases the HEAU closed during FY 2014, 435 or 72% involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 435 cases involved more than one carrier.

1. The HEAU experienced a noticeable drop in appeals and grievances related cases from FY 2013. In FY 2013, 29% of the appeals and grievances cases were eligibility disputes; largely denials based on pre-existing conditions. Effective January 1, 2014, consumers could no longer be denied insurance due to pre-existing conditions. In FY 2014, only 17% of the appeals and grievances cases were eligibility disputes. The HEAU expects an increase in enrollment cases during the 2014-2015 and future open enrollment periods on the Exchange when the HEAU assists consumers with resolving problems with enrollment in qualified health plans and obtaining premium tax credits and cost-sharing reductions.
2. Of the 435 appeals and grievances cases (439 carriers involved) the HEAU mediated during FY 2014, 259 (59%) related to MIA-regulated plans.
3. Of the 435 cases the HEAU mediated during FY 2014, 37% were adverse decision (*medical necessity*) cases, 46% were coverage decision (*contractual exclusion*) cases, and 17% were eligibility denials.
4. The HEAU mediation process resulted in carriers overturning or modifying 53% of the appeals and grievances cases. The carriers overturned or modified 53% of the medical necessity cases, 55% of the coverage decision cases, and 49% of the eligibility denial cases.
5. In cases filed against carriers subject to MIA review, the HEAU mediation efforts resulted in carriers changing their decisions 56% of the time. For non-regulated plans, the HEAU efforts resulted in carriers changing their decisions 49% of the time. In FY 2013, there was a noticeable increase in the positive outcomes for consumers in non-regulated plans with carriers changing their decisions in 48% of the cases. In

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<sup>9</sup> This report does not contain detailed data related to the outcomes of cases handled by the 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 nearly 10,000 calls), more need for education, and a greater complexity in the cases handled.

fiscal years 2010, 2011 and 2012, positive outcomes were obtained in 35%, 31% and 39% of the cases respectively. The increase in positive outcomes continued in FY 2014, with 49% of the denials overturned or modified. The HEAU attributes the positive increase to the ACA mandated independent external review of medical necessity denials for non-regulated plans.

6. In FY 2014, the HEAU formally assisted 114 consumers in identifying available health insurance options.
7. In FY 2014, the HEAU assisted patients in recovering or saving more than \$1.9 million dollars, over \$1.4 million of which pertained to appeals and grievances cases.

## Appendix

**Carrier Cases  
Adverse Decisions, Grievances and Outcomes**

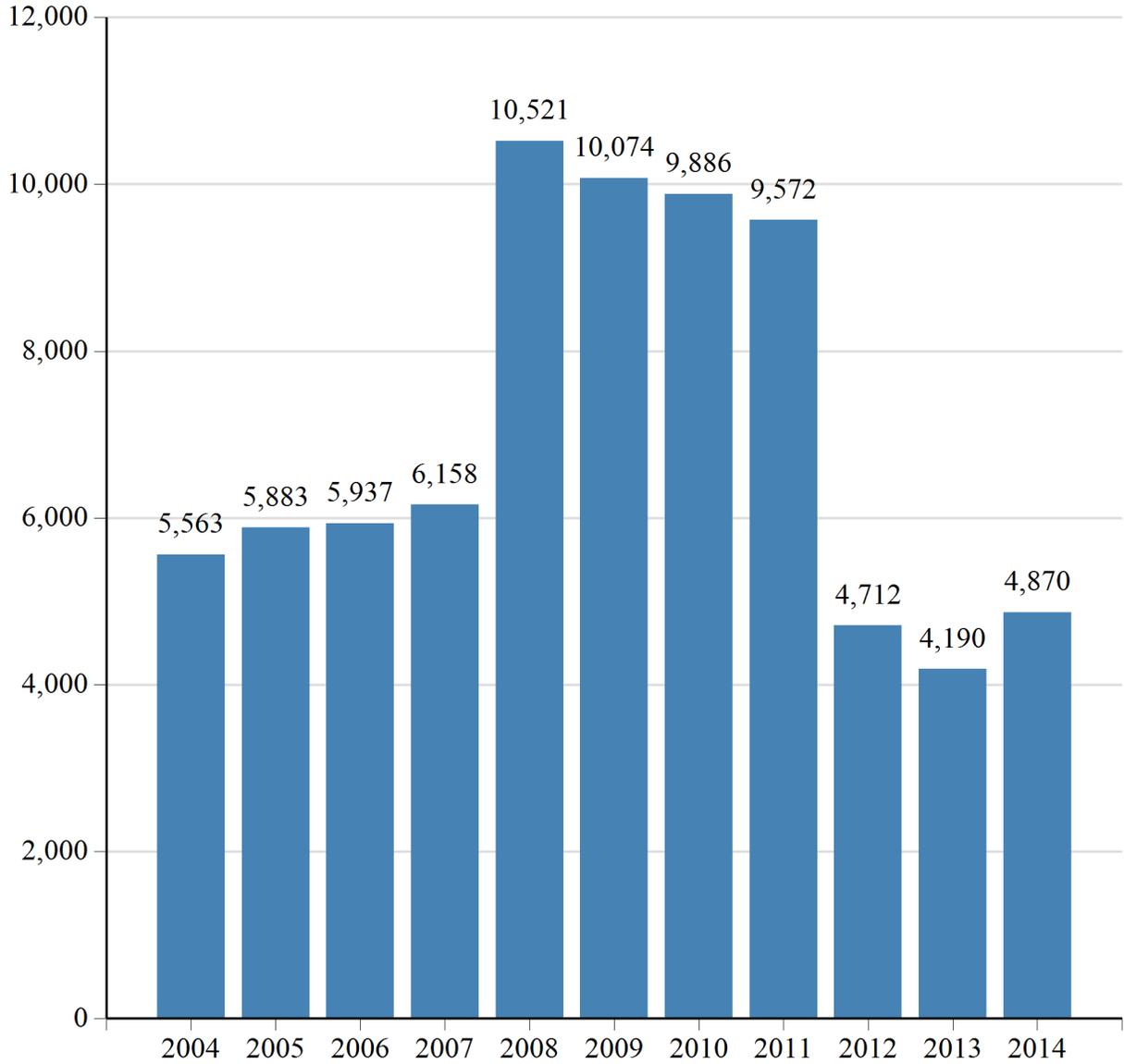
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overtured/ Modified
Aetna Dental Inc.	579	0	0	0%	0%
Aetna Health Inc.	127	4	97	65%	35%
Aetna Life Insurance Company	336	18	301	60%	40%
All Savers Insurance Company	5	0	0	0%	0%
Ameritas Life Insurance Corp.	158	0	38	55%	45%
CareFirst BlueChoice, Inc.	6,722	0	684	34%	66%
Carefirst of Maryland, Inc.	2,826	0	293	36%	64%
CIGNA Dental Health of Maryland, Inc.	78	0	0	0%	0%
CIGNA Health and Life Insurance Company	4,717	25	195	59%	41%
Connecticut General Life Insurance Company	267	7	62	65%	35%
Coventry Health and Life Insurance Company	414	13	277	86%	14%
Coventry Health Care of Delaware, Inc.	1,351	59	805	74%	26%
Delta Dental of Pennsylvania	2	0	0	0%	0%
Dental Benefit Providers of Illinois, Inc.	15	0	14	50%	50%
Evergreen Health Cooperative Inc.	7	0	1	0%	100%
Golden Rule Insurance Company	66	2	22	73%	27%
Group Dental Service of Maryland, Inc.	1,801	699	15	47%	53%
Group Hospitalization and Medical Services, Inc.	5,410	0	426	41%	59%
Guardian Life Insurance Company of America	692	0	301	35%	65%
HumanaDental Insurance Company	118	2	19	68%	32%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overtured/ Modified
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	1,013	4	65	55%	45%
Kaiser Permanente Insurance Company	75	0	16	56%	44%
Lincoln National Life Insurance Company	50	0	0	0%	0%
Madison National Life Insurance Company, Inc.	0	1	1	0%	100%
MAMSI Life and Health Insurance Company	124	0	1	0%	100%
MD-Individual Practice Association, Inc.	2	0	87	51%	49%
Metropolitan Life Insurance Company	278	34	8	13%	88%
Optimum Choice, Inc.	899	0	113	58%	42%
Principal Life Insurance Company	4	0	4	50%	50%
Reliance Standard Life Insurance Company	36	0	6	67%	33%
Standard Insurance Company	22	0	2	0%	100%
Standard Security Life Insurance Company of New York	0	0	7	86%	14%
Sun Life Assurance Company of Canada	74	0	22	86%	14%
Time Insurance Company	8	1	2	50%	50%
Union Security Insurance Company	177	8	38	24%	76%
United Concordia Dental Plans, Inc.	2	0	1	100%	0%
United Concordia Life and Health Insurance Company	1,542	0	368	43%	57%
United States Life Insurance Company In the City of New York	2	0	2	50%	50%
UnitedHealthcare Insurance Company	1,840	0	305	39%	61%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overtured/ Modified
UnitedHealthcare of the Mid-Atlantic, Inc.	532	0	78	69%	31%
<b>Total</b>	<b>32,512</b>	<b>881</b>	<b>4,870</b>	<b>53%</b>	<b>47%</b>

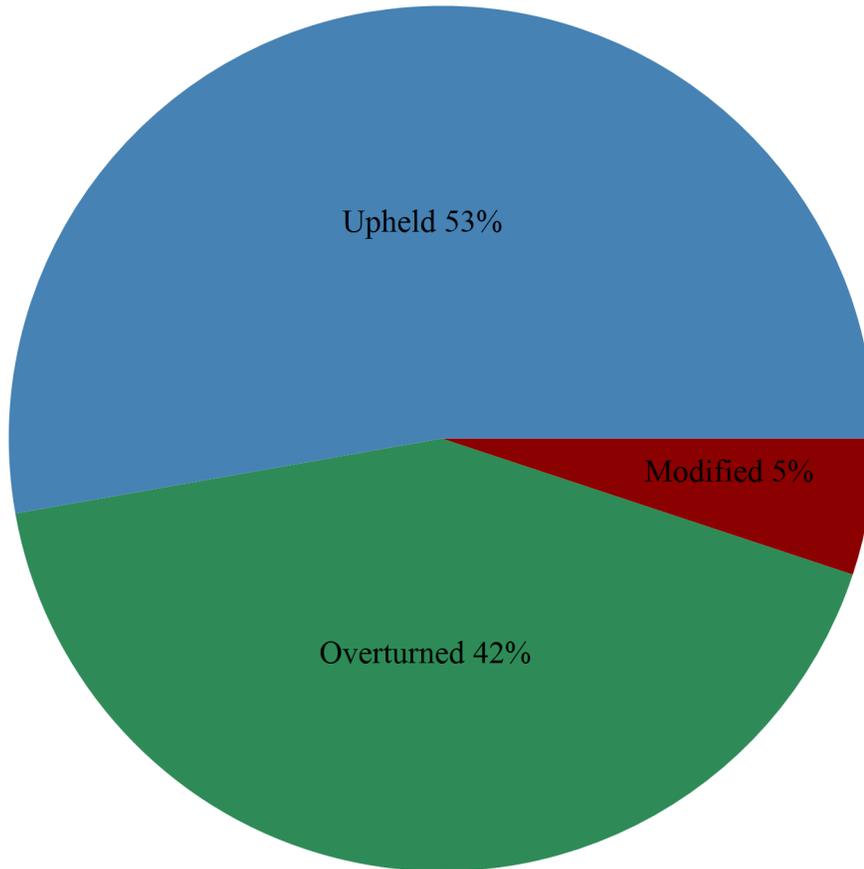
**Carrier Grievances Cases  
Number of Grievances Since Fiscal Year 2004**

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.



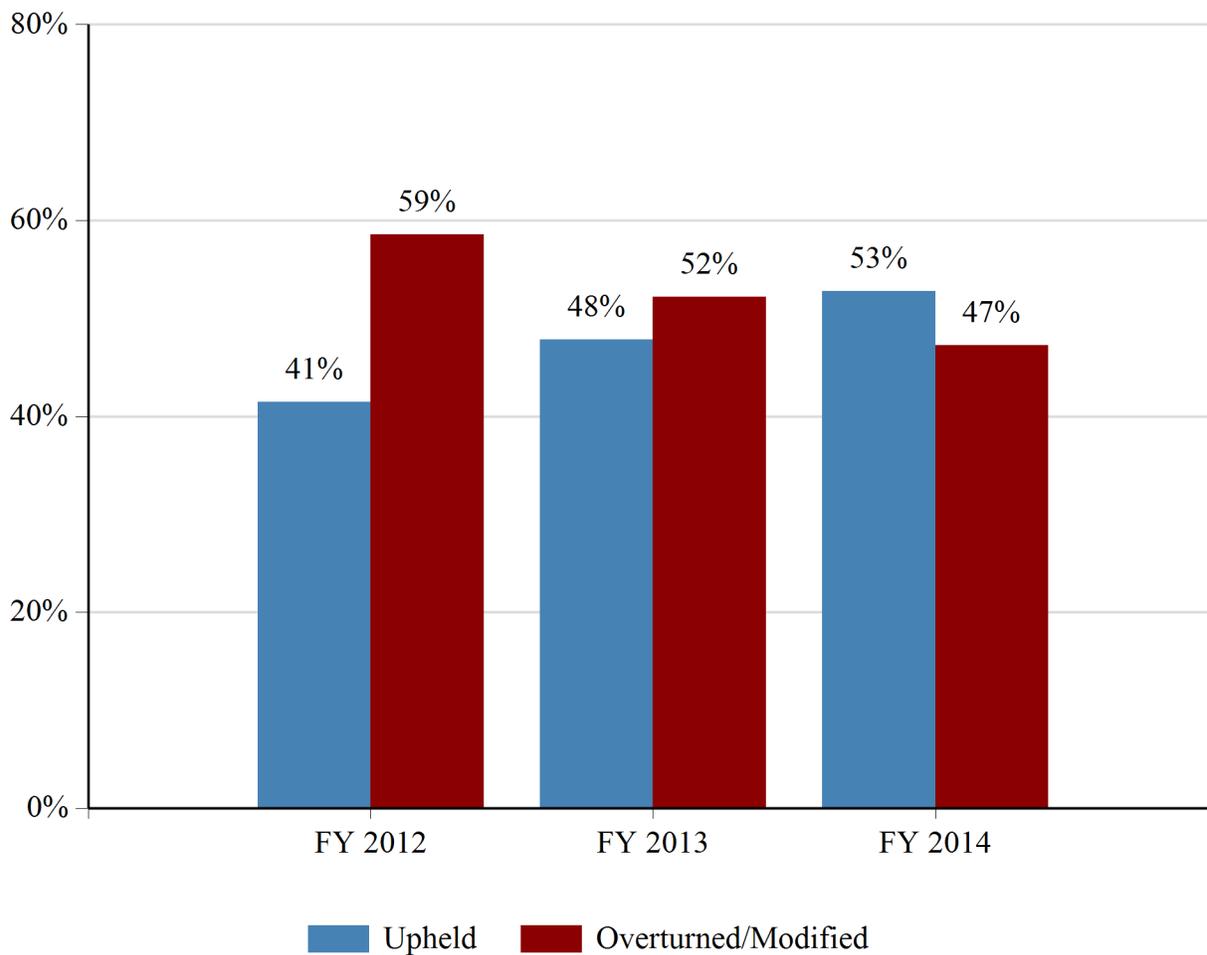
## Carrier Grievances Cases Outcomes

The chart below describes the outcomes of the 4,870 internal grievances filed with carriers in FY 2014, 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 2014, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
	Count	Percentage	Count	Percentage
Durable Medical Equipment	1,958	6.022%	144	2.957%
Emergency Room	241	0.741%	381	7.823%
Home Health	201	0.618%	28	0.575%
Inpatient Hospital	1,622	4.989%	446	9.158%
Laboratory, Radiology	10,793	33.197%	768	15.770%
Mental Health / Substance Abuse	724	2.227%	197	4.045%
Other	194	0.597%	128	2.628%
Pharmacy	3,155	9.704%	529	10.862%
Physician	4,823	14.835%	1,046	21.478%
Podiatry, Dental, Optometry, Chiropractic	7,700	23.684%	1,115	22.895%
PT, OT, ST	1,047	3.220%	78	1.602%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	54	0.166%	10	0.205%
<b>Total</b>	<b>32,512</b>	<b>100%</b>	<b>4,870</b>	<b>100%</b>

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

### Carrier Grievances Cases Outcomes by Service Type

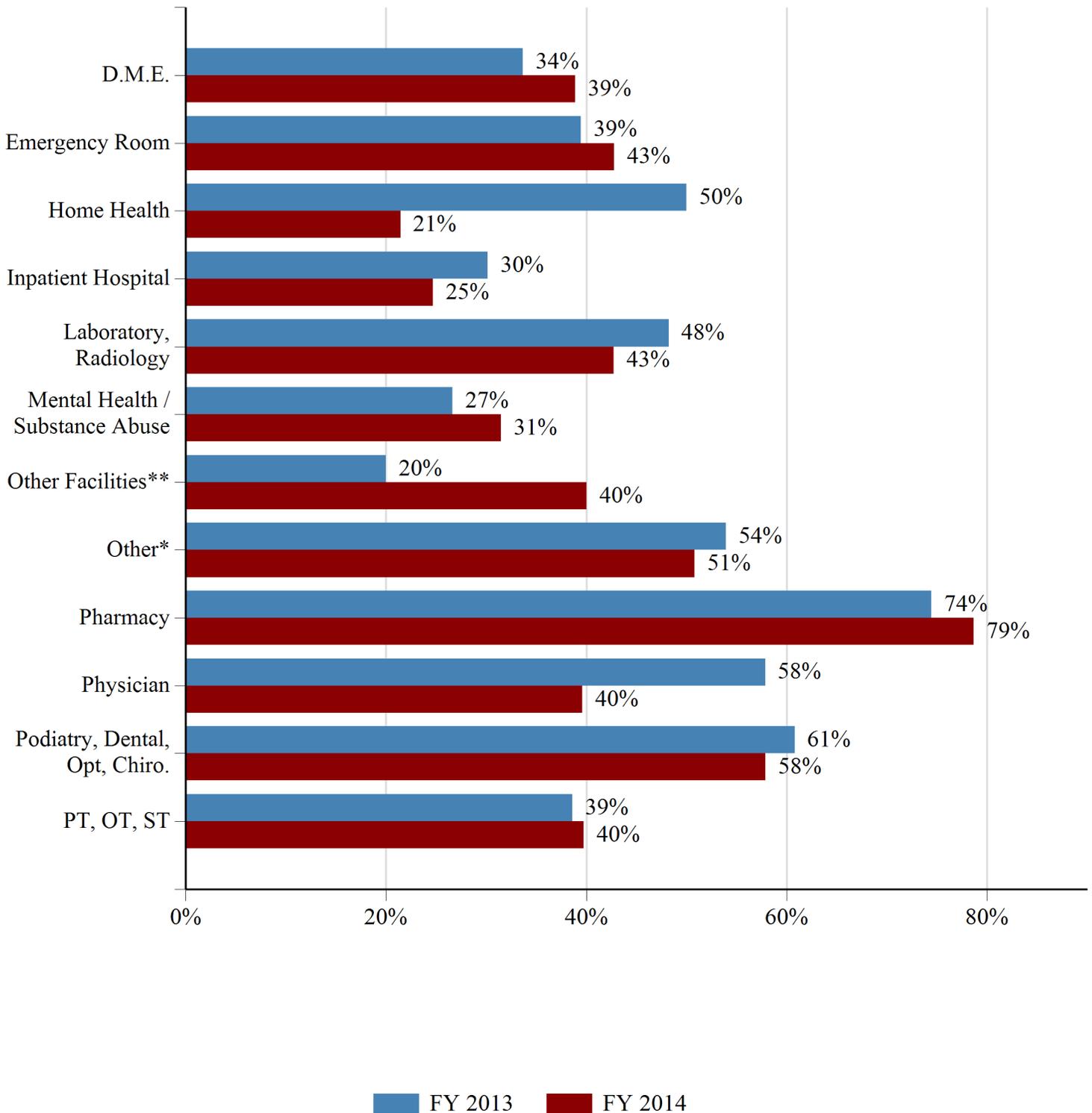
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overtured/ Modified
Durable Medical Equipment	144	61%	39%
Emergency Room	381	57%	43%
Home Health	28	79%	21%
Inpatient Hospital	446	75%	25%
Laboratory, Radiology	768	57%	43%
Mental Health / Substance Abuse	197	69%	31%
Other	128	49%	51%
Pharmacy	529	21%	79%
Physician	1046	60%	40%
Podiatry, Dental, Optometry, Chiropractic	1115	42%	58%
PT, OT, ST	78	60%	40%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	10	60%	40%
<b>Total</b>	<b>4,870</b>	<b>53%</b>	<b>47%</b>

\*"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 2013 and FY 2014.



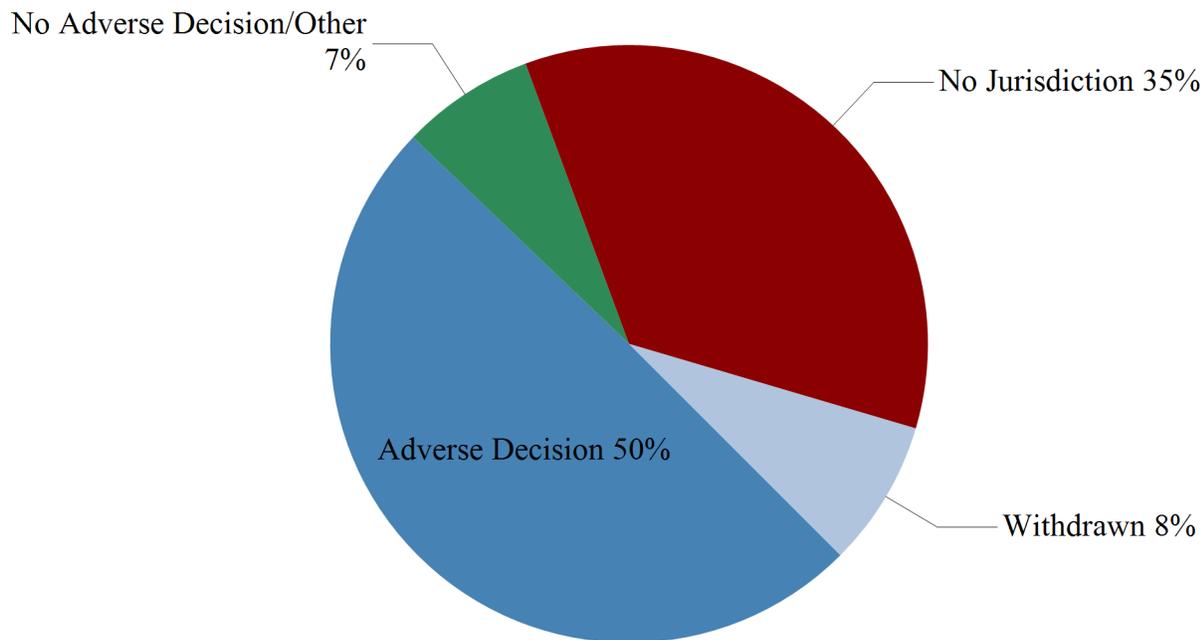
\* "Other" means cases where the type of service did not fit an existing category.

\*\* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.

## MIA Appeals and Grievances Complaints Initial Review of Cases

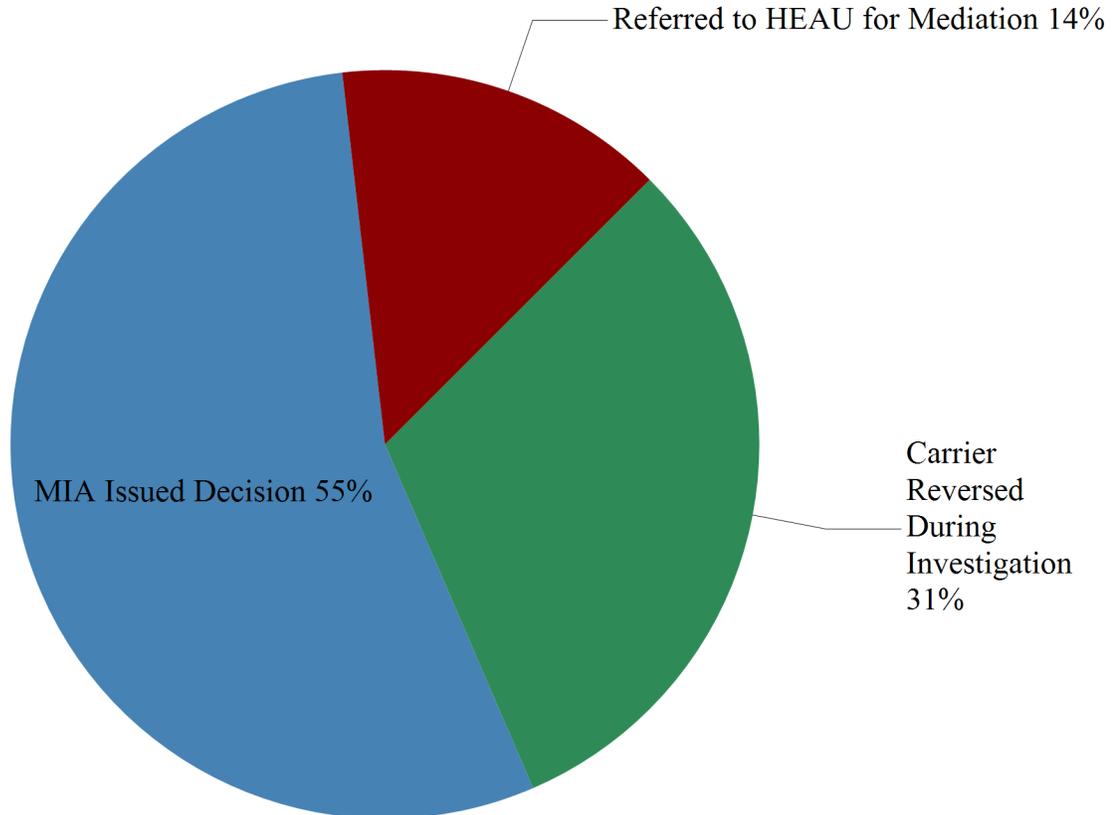
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some 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 844 cases filed with the MIA's Appeals and Grievances Unit during FY 2014.



## MIA Appeals and Grievances Complaints Initial Disposition of Grievances

During FY 2014, the MIA determined that 419 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 60 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 419 grievances the MIA reviewed during FY 2014.



**MIA Appeals and Grievances Cases  
Carriers and Disposition**

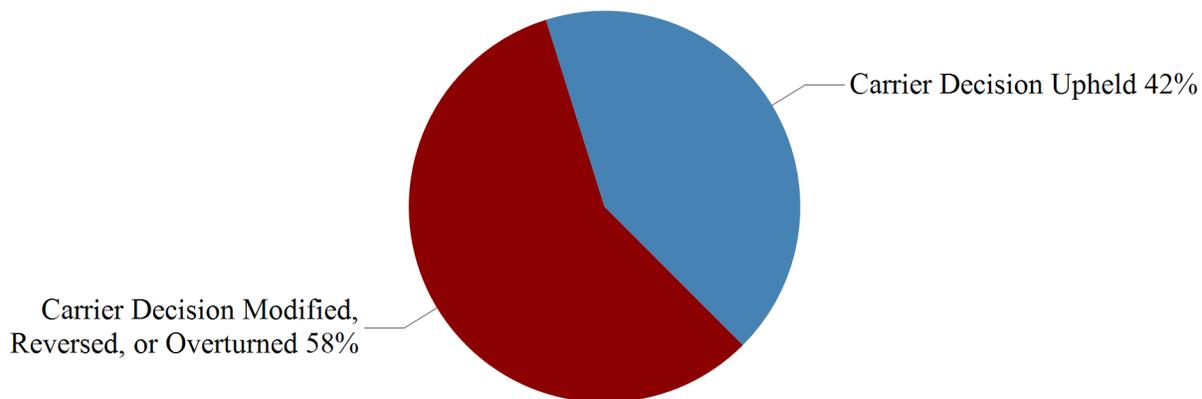
The table below details the outcomes of the 359 grievances complaints the MIA investigated during FY 2014. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
		Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Aetna Health Inc.	7	4	57.1%	2	28.6%	0	0.0%	1	14.3%
Aetna Life Insurance Company	19	7	36.8%	5	26.3%	0	0.0%	7	36.8%
APS Healthcare	5	1	20.0%	0	0.0%	3	60.0%	1	20.0%
CareFirst BlueChoice, Inc.	63	13	20.6%	13	20.6%	2	3.2%	35	55.6%
Carefirst of Maryland, Inc.	62	25	40.3%	14	22.6%	0	0.0%	23	37.1%
CIGNA Health and Life Insurance Company	6	3	50.0%	1	16.7%	0	0.0%	2	33.3%
Coventry Health and Life Insurance Company	8	3	37.5%	0	0.0%	1	12.5%	4	50.0%
Coventry Health Care of Delaware, Inc.	9	4	44.4%	3	33.3%	0	0.0%	2	22.2%
DentaQuest Mid-Atlantic, Inc.	2	2	100.0%	0	0.0%	0	0.0%	0	0.0%
Express Scripts Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Express Scripts, Inc.	4	0	0.0%	0	0.0%	0	0.0%	4	100.0%
Golden Rule Insurance Company	6	3	50.0%	2	33.3%	0	0.0%	1	16.7%
Group Dental Service of Maryland, Inc.	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
Group Hospitalization and Medical Services, Inc.	35	17	48.6%	8	22.9%	0	0.0%	10	28.6%
Guardian Insurance & Annuity Company, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Guardian Life Insurance Company of America	13	6	46.2%	4	30.8%	1	7.7%	2	15.4%

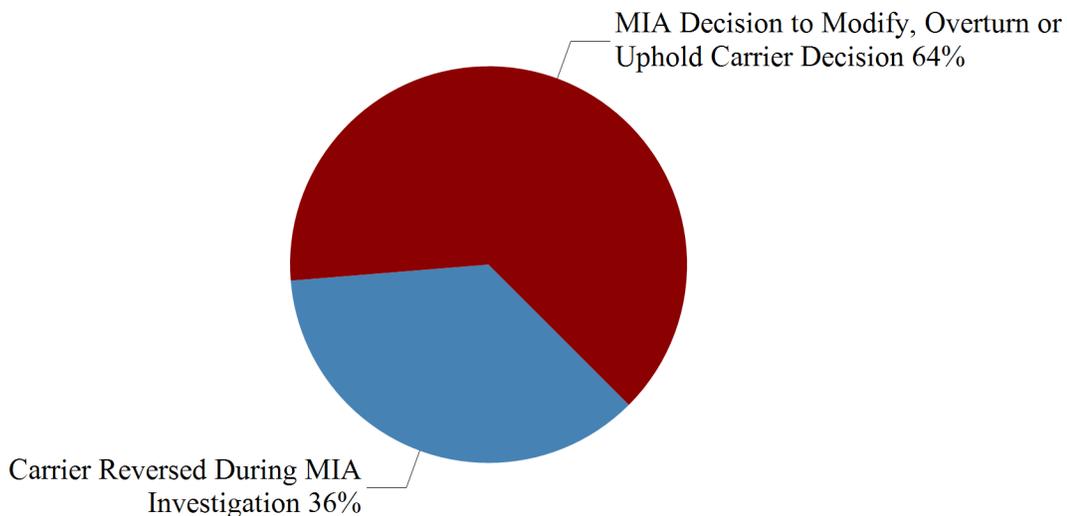
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
		Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	11	8	72.7%	0	0.0%	1	9.1%	2	18.2%
MAMSI Life and Health Insurance Company	12	6	50.0%	3	25.0%	0	0.0%	3	25.0%
Maryland Health Insurance Plan	10	7	70.0%	1	10.0%	0	0.0%	2	20.0%
Metropolitan Life Insurance Company	3	0	0.0%	0	0.0%	0	0.0%	3	100.0%
Optimum Choice, Inc.	10	6	60.0%	1	10.0%	0	0.0%	3	30.0%
Principal Life Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Sun Life Assurance Company of Canada	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Union Security Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
United Concordia Life and Health Insurance Company	17	12	70.6%	0	0.0%	1	5.9%	4	23.5%
UnitedHealthcare Insurance Company	32	15	46.9%	7	21.9%	0	0.0%	10	31.3%
UnitedHealthcare of the Mid-Atlantic, Inc.	7	4	57.1%	0	0.0%	1	14.3%	2	28.6%
UnitedHealthcare Services, Inc.	11	4	36.4%	3	27.3%	0	0.0%	4	36.4%
<b>Total</b>	<b>359</b>	<b>152</b>	<b>42%</b>	<b>67</b>	<b>19%</b>	<b>10</b>	<b>3%</b>	<b>130</b>	<b>36%</b>

### MIA Appeals and Grievances Cases Disposition Following Investigation

The chart below reflects the overall outcomes of the 359 grievances the MIA investigated during FY 2014.

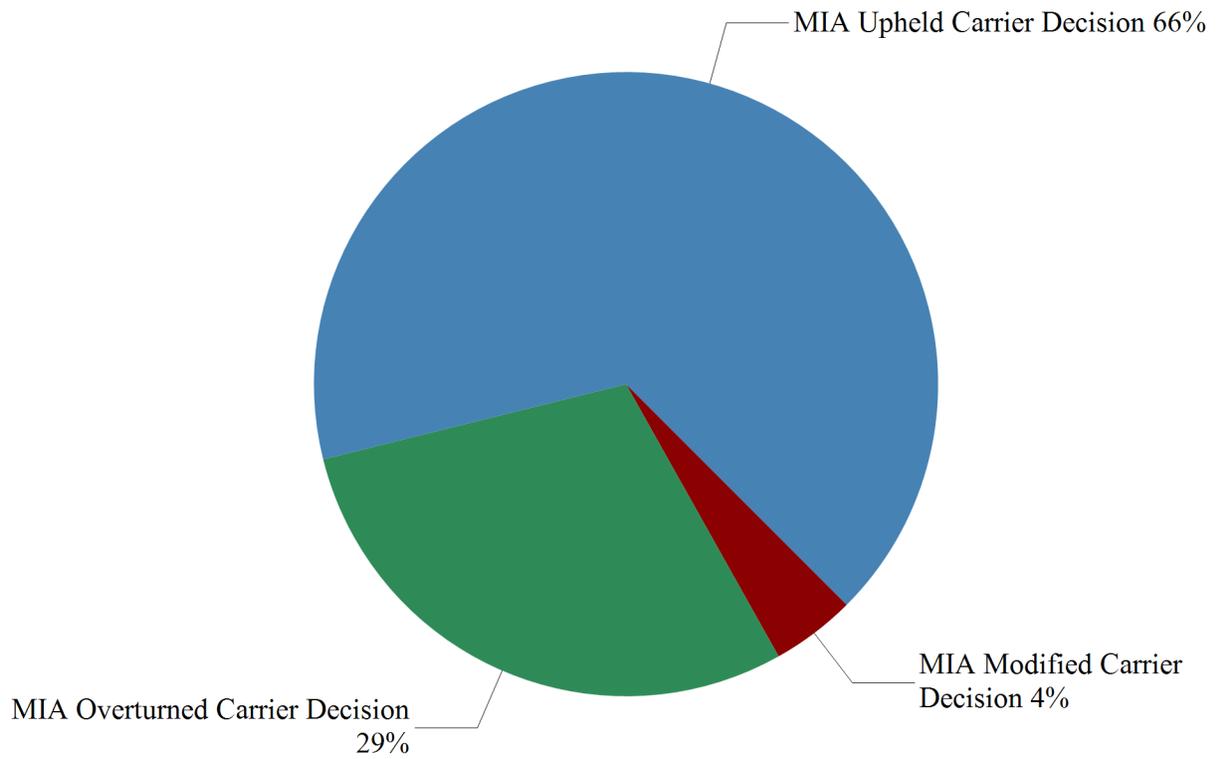


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



### MIA Appeals and Grievances Cases Disposition Resulting from IRO Review

The chart below describes the outcomes of the 229 cases the MIA forwarded to an IRO for review in FY 2014.



Percentage may not equal 100% due to rounding.

**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 2014. 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.

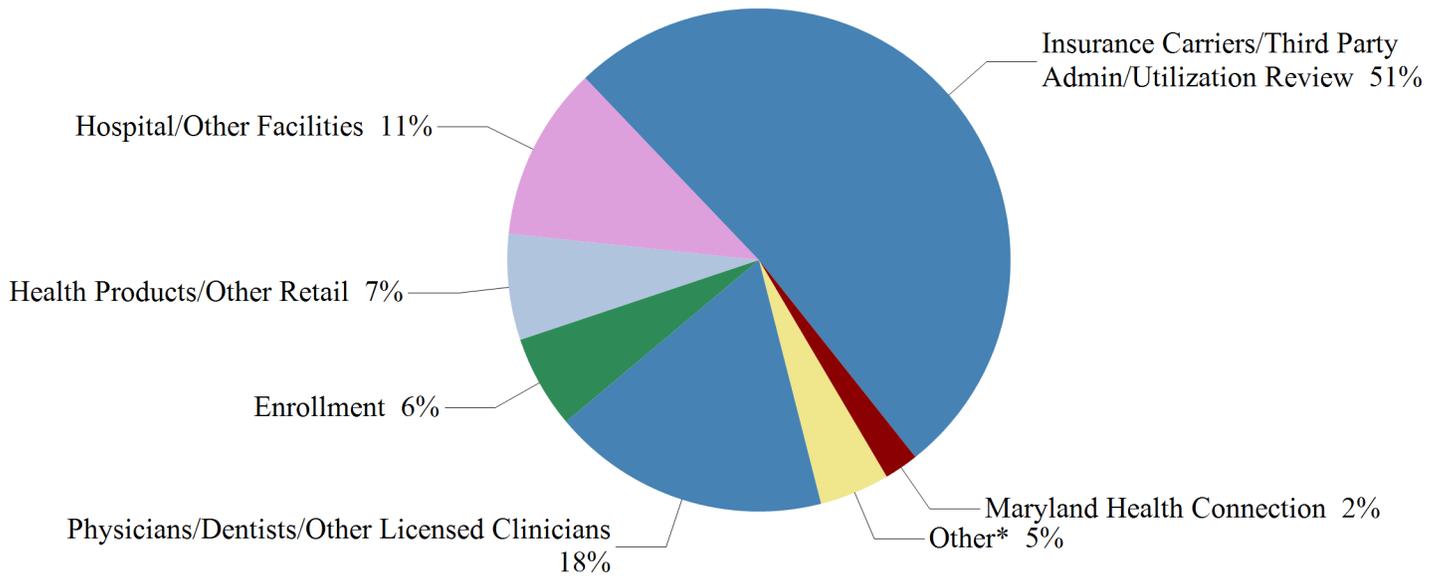
Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Acupuncture	1	0.28%	1	100%	0	0%	0	0%	0	0%
Chiropractic Care Services	5	1.39%	4	80%	0	0%	0	0%	1	20%
Cosmetic	12	3.34%	6	50%	2	17%	0	0%	4	33%
Denial of Hospital Days	8	2.23%	5	63%	3	38%	0	0%	0	0%
Dental Care Services	66	18.38%	29	44%	11	17%	2	3%	24	36%
Durable Medical Equipment	13	3.62%	5	38%	3	23%	0	0%	5	38%
Emergency Room Denial	1	0.28%	1	100%	0	0%	0	0%	0	0%
Emergency Treatment Denial	1	0.28%	0	0%	0	0%	0	0%	1	100%
Experimental	62	17.27%	35	56%	20	32%	0	0%	7	11%
Home Care Services	2	0.56%	0	0%	1	50%	0	0%	1	50%
In-Patient Rehabilitation Services	3	0.84%	0	0%	2	67%	0	0%	1	33%
Lab, Imaging, Test Services	17	4.74%	6	35%	3	18%	0	0%	8	47%
Medical Food	1	0.28%	0	0%	0	0%	0	0%	1	100%
Mental Health Partial Hospitalization	4	1.11%	3	75%	0	0%	0	0%	1	25%
Mental Health/Substance Abuse (Inpatient) Services	24	6.69%	9	38%	5	21%	4	17%	6	25%
Mental Health/Substance Abuse (Outpatient) Services	18	5.01%	10	56%	1	6%	1	6%	6	33%
Morbid Obesity	1	0.28%	0	0%	0	0%	0	0%	1	100%
No Preauthorization	1	0.28%	0	0%	0	0%	0	0%	1	100%
Nursing Home Services	1	0.28%	0	0%	1	100%	0	0%	0	0%
Out-of-Network Benefits	4	1.11%	2	50%	0	0%	0	0%	2	50%
Outpatient Services	1	0.28%	1	100%	0	0%	0	0%	0	0%

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
PCP Referrals	3	0.84%	2	67%	0	0%	0	0%	1	33%
Pharmacy Benefits	1	0.28%	0	0%	0	0%	1	100%	0	0%
Pharmacy Services/Formulary Issues	60	16.71%	9	15%	10	17%	1	2%	40	67%
Physician Services	37	10.31%	18	49%	2	5%	1	3%	16	43%
Preventive Care	1	0.28%	0	0%	0	0%	0	0%	1	100%
PT, OT, ST Services	9	2.51%	5	56%	2	22%	0	0%	2	22%
Skilled Nursing Facility Care Services	2	0.56%	1	50%	1	50%	0	0%	0	0%
<b>Total</b>	<b>359</b>	<b>100%</b>	<b>152</b>	<b>42%</b>	<b>67</b>	<b>19%</b>	<b>10</b>	<b>3%</b>	<b>130</b>	<b>36%</b>

Percentages may not equal 100% due to rounding.

## HEAU Cases Subject of Complaints

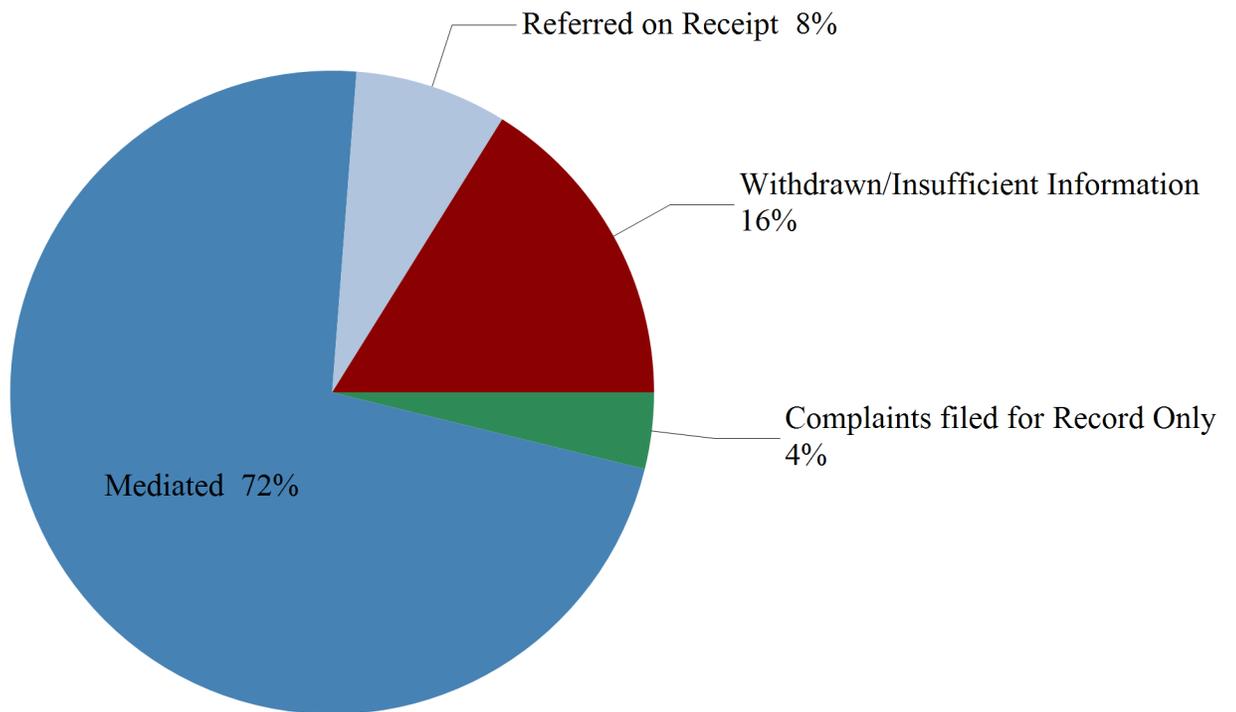
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but the HEAU cases also involve access to medical records, sales and service problems with health care products, 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. The HEAU provided enrollment assistance until open enrollment began on Maryland Health Connection in October 2013. Thereafter, the HEAU assisted consumers who experienced enrollment difficulties on Maryland Health Connection. The traditional enrollment cases are noted as enrollment. The chart below shows the types of industries involved in the cases the HEAU closed during FY 2014. The HEAU closed 1,864 complaints. Some complaints were filed against more than one industry.



\* "Other" includes Collection/Billing Entities (1.2%), Laboratories (.8%), Government Agency (.7%), Ambulance (.6%), Medical Record Copying Service (.6%), and other non-specific categories (e.g. Telemarketing).

## HEAU Appeals and Grievances Cases Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Some consumers, or other persons, file complaints but never complete an authorization to release medical records, a form required by the HEAU to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. The chart below details the initial disposition of the Appeals and Grievances cases closed by the HEAU during FY 2014.



**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 2014. 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 2014.

<b>Carrier</b>	<b>Total Cases</b>	<b>Upheld</b>		<b>Overtured/Modified</b>	
<b>Aetna</b>					
State Regulated	23	12	52%	11	48%
Not State Regulated	24	11	46%	13	54%
<b>Total Complaints</b>	<b>47</b>	<b>23</b>	<b>49%</b>	<b>24</b>	<b>51%</b>
<b>Allegiance</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Amerigroup</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Anthem Blue Cross Blue Shield</b>					
Not State Regulated	5	3	60%	2	40%
<b>Total Complaints</b>	<b>5</b>	<b>3</b>	<b>60%</b>	<b>2</b>	<b>40%</b>
<b>Anthem UM Services, Inc.</b>					
Not State Regulated	2	2	100%	0	0%
<b>Total Complaints</b>	<b>2</b>	<b>2</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>APS Healthcare Bethesda, Inc.</b>					
State Regulated	2	0	0%	2	100%
<b>Total Complaints</b>	<b>2</b>	<b>0</b>	<b>0%</b>	<b>2</b>	<b>100%</b>

Carrier	Total Cases	Upheld	Overturned/Modified		
<b>Arkansas BlueCross BlueShield</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>Blue Cross Blue Shield - Florida</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Blue Cross Blue Shield of Illinois</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>BlueAdvantage Administrators of Arkansas</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>Bravo Health - HealthSpring, Inc.</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>CareFirst BlueChoice</b>					
State Regulated	57	24	42%	33	58%
Not State Regulated	3	2	67%	1	33%
<b>Total Complaints</b>	<b>60</b>	<b>26</b>	<b>43%</b>	<b>34</b>	<b>57%</b>
<b>CareFirst of Maryland</b>					
State Regulated	78	27	35%	51	65%
Not State Regulated	17	9	53%	8	47%
<b>Total Complaints</b>	<b>95</b>	<b>36</b>	<b>38%</b>	<b>59</b>	<b>62%</b>

Carrier	Total Cases	Upheld	Overturned/Modified		
<b>CareFirst the Dental Network</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>CIGNA</b>					
State Regulated	6	2	33%	4	67%
Not State Regulated	21	8	38%	13	62%
<b>Total Complaints</b>	<b>27</b>	<b>10</b>	<b>37%</b>	<b>17</b>	<b>63%</b>
<b>CoreSource External Appeals</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>CoreSource, A Trustmark Company</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>Coventry Health Care</b>					
State Regulated	6	2	33%	4	67%
Not State Regulated	2	1	50%	1	50%
<b>Total Complaints</b>	<b>8</b>	<b>3</b>	<b>37.5%</b>	<b>5</b>	<b>62.5%</b>
<b>CVS Caremark</b>					
Not State Regulated	3	3	100%	0	0%
<b>Total Complaints</b>	<b>3</b>	<b>3</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>Delta Dental of California</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>

Carrier	Total Cases	Upheld	Overturned/Modified		
<b>Delta Dental of Iowa</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>Delta Dental of Virginia</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Express Scripts</b>					
State Regulated	3	0	0%	3	100%
Not State Regulated	3	0	0%	3	100%
<b>Total Complaints</b>	<b>6</b>	<b>0</b>	<b>0%</b>	<b>6</b>	<b>100%</b>
<b>FELRA &amp; UFCW Health and Welfare Fund</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>Golden Rule Insurance</b>					
State Regulated	12	10	83%	2	17%
Not State Regulated	11	7	64%	4	36%
<b>Total Complaints</b>	<b>23</b>	<b>17</b>	<b>74%</b>	<b>6</b>	<b>26%</b>
<b>Government Employees Health Association (GEHA)</b>					
Not State Regulated	2	1	50%	1	50%
<b>Total Complaints</b>	<b>2</b>	<b>1</b>	<b>50%</b>	<b>1</b>	<b>50%</b>
<b>Group Benefit Services, Inc.</b>					
Not State Regulated	2	1	50%	1	50%
<b>Total Complaints</b>	<b>2</b>	<b>1</b>	<b>50%</b>	<b>1</b>	<b>50%</b>

Carrier	Total Cases	Upheld	Overturned/Modified		
<b>Guardian Life insurance Company of America</b>					
State Regulated	3	1	33%	2	67%
Not State Regulated	3	2	67%	1	33%
<b>Total Complaints</b>	<b>6</b>	<b>3</b>	<b>50%</b>	<b>3</b>	<b>50%</b>
<b>Independence Blue Cross Blue Shield</b>					
Not State Regulated	2	0	0%	2	100%
<b>Total Complaints</b>	<b>2</b>	<b>0</b>	<b>0%</b>	<b>2</b>	<b>100%</b>
<b>InforMed, LLC</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>Johns Hopkins Employer Health Programs</b>					
Not State Regulated	3	2	67%	1	33%
<b>Total Complaints</b>	<b>3</b>	<b>2</b>	<b>67%</b>	<b>1</b>	<b>33%</b>
<b>Johns Hopkins-Tricare</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Kaiser Permanente of the Mid Atlantic States</b>					
State Regulated	13	10	77%	3	23%
Not State Regulated	2	1	50%	1	50%
<b>Total Complaints</b>	<b>15</b>	<b>11</b>	<b>73%</b>	<b>4</b>	<b>27%</b>
<b>Magellan Behavioral Health</b>					
State Regulated	2	1	50%	1	50%
<b>Total Complaints</b>	<b>2</b>	<b>1</b>	<b>50%</b>	<b>1</b>	<b>50%</b>

Carrier	Total Cases	Upheld	Upheld	Overtaken/Modified	Overtaken/Modified
<b>Maryland Health Connection</b>					
State Regulated	5	0	0%	5	100%
<b>Total Complaints</b>	<b>5</b>	<b>0</b>	<b>0%</b>	<b>5</b>	<b>100%</b>
<b>Maryland Health Insurance Plan (MHIP)</b>					
State Regulated	5	3	60%	2	40%
<b>Total Complaints</b>	<b>5</b>	<b>3</b>	<b>60%</b>	<b>2</b>	<b>40%</b>
<b>MDIPA</b>					
Not State Regulated	3	1	33%	2	67%
<b>Total Complaints</b>	<b>3</b>	<b>1</b>	<b>33%</b>	<b>2</b>	<b>67%</b>
<b>Medicare</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>MedSolutions</b>					
Not State Regulated	2	1	50%	1	50%
<b>Total Complaints</b>	<b>2</b>	<b>1</b>	<b>50%</b>	<b>1</b>	<b>50%</b>
<b>Meritain Health Incorporated</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>Metlife Dental Claims</b>					
State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Metropolitan Life Insurance Company</b>					
State Regulated	3	1	33%	2	67%
Not State Regulated	3	2	67%	1	33%
<b>Total Complaints</b>	<b>6</b>	<b>3</b>	<b>50%</b>	<b>3</b>	<b>50%</b>

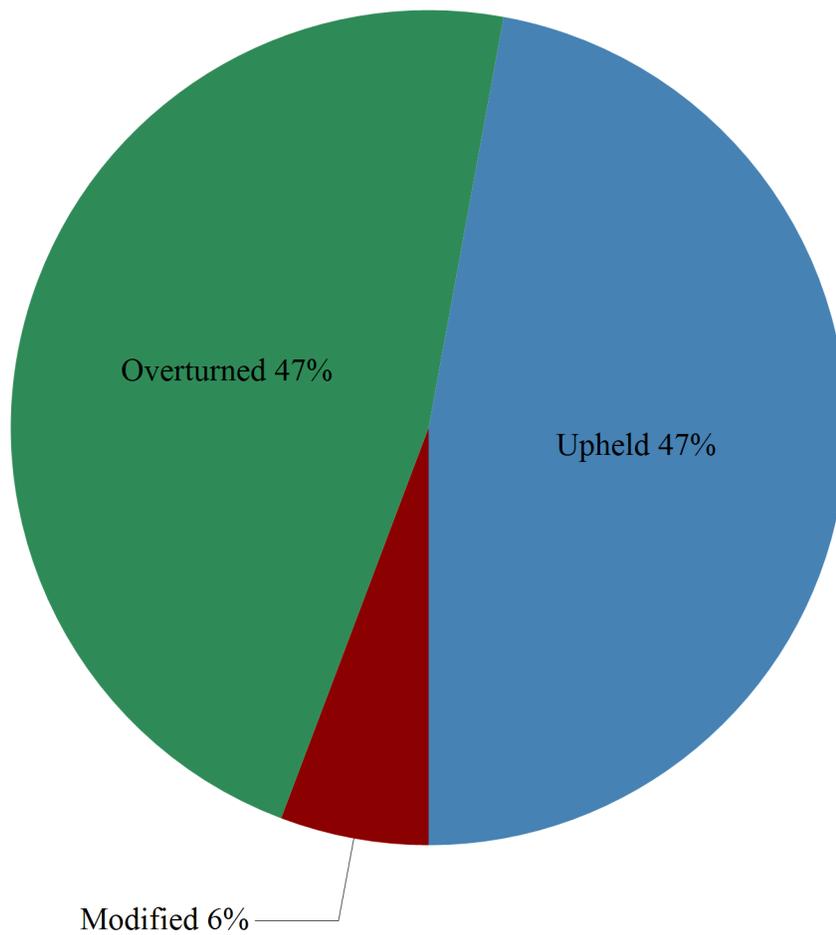
Carrier	Total Cases	Upheld		Overturned/Modified	
<b>National Claims Administrative Services</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>OneNet PPO</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Optimum Choice</b>					
State Regulated	2	1	50%	1	50%
Not State Regulated	3	0	0%	3	100%
<b>Total Complaints</b>	<b>5</b>	<b>1</b>	<b>20%</b>	<b>4</b>	<b>80%</b>
<b>Principal Financial Group</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Principal Life Insurance Company</b>					
State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Samba</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>The Taney Corporation Employee Benefit Plan</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>

Carrier	Total Cases	Upheld	Overturned/Modified		
<b>Transamerica Life Insurance Company</b>					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>2</b>	<b>2</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>Tricare</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>UMR</b>					
Not State Regulated	1	1	100%	0	0%
<b>Total Complaints</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>0</b>	<b>0%</b>
<b>United Behavioral Health</b>					
State Regulated	2	1	50%	1	50%
Not State Regulated	2	0	0%	2	100%
<b>Total Complaints</b>	<b>4</b>	<b>1</b>	<b>25%</b>	<b>3</b>	<b>75%</b>
<b>United Concordia Companies, Inc.</b>					
State Regulated	12	8	67%	4	33%
Not State Regulated	7	6	86%	1	14%
<b>Total Complaints</b>	<b>19</b>	<b>14</b>	<b>74%</b>	<b>5</b>	<b>26%</b>
<b>United Healthcare</b>					
State Regulated	22	9	41%	13	59%
Not State Regulated	27	15	56%	12	44%
<b>Total Complaints</b>	<b>49</b>	<b>24</b>	<b>49%</b>	<b>25</b>	<b>51%</b>
<b>United Healthcare Insurance Company of New York</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>

Carrier	Total Cases	Upheld		Overturned/Modified	
<b>Value Options</b>					
Not State Regulated	1	0	0%	1	100%
<b>Total Complaints</b>	<b>1</b>	<b>0</b>	<b>0%</b>	<b>1</b>	<b>100%</b>
<b>Totals</b>					
State Regulated	259	113	43.6%	146	56.4%
Not State Regulated	180	92	51.1%	88	48.9%
<b>TOTALS</b>	<b>439</b>	<b>205</b>	<b>47%</b>	<b>234</b>	<b>53%</b>

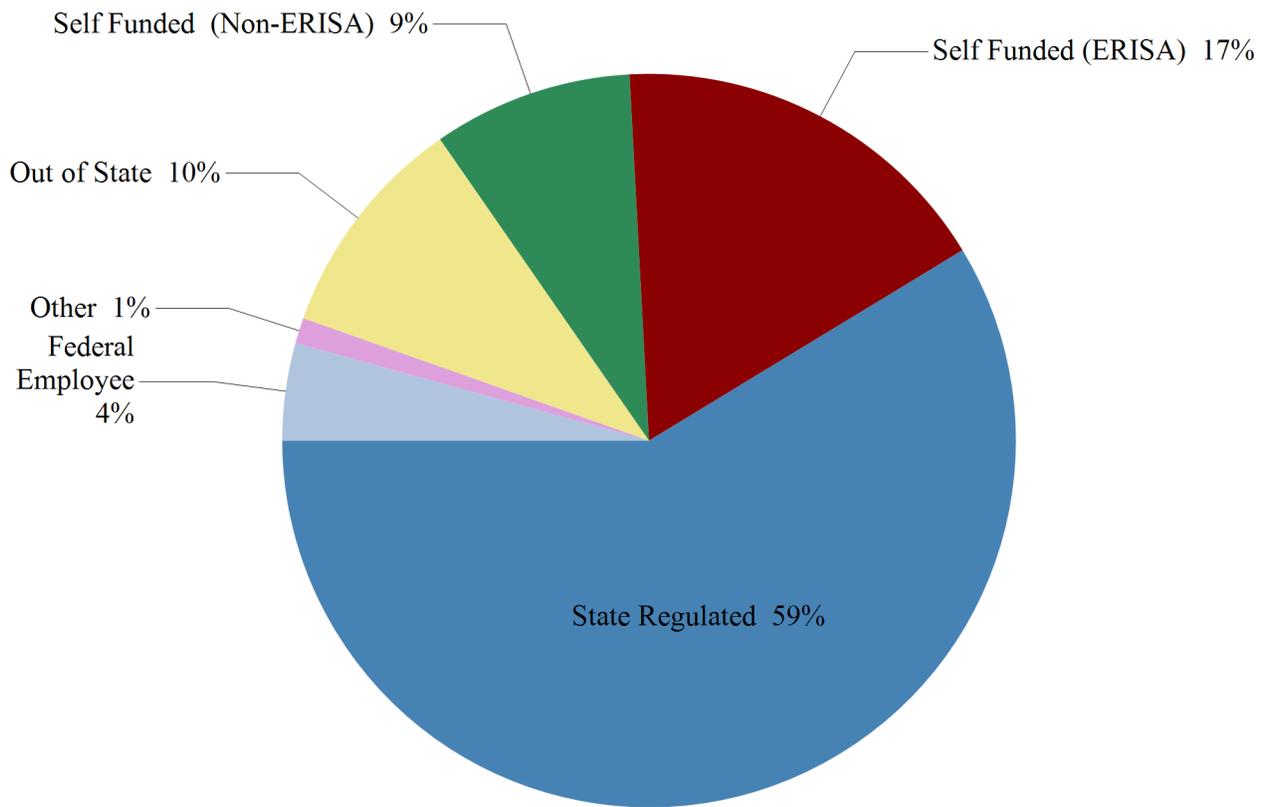
## HEAU Mediated Appeals and Grievances Cases Disposition

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 2014.



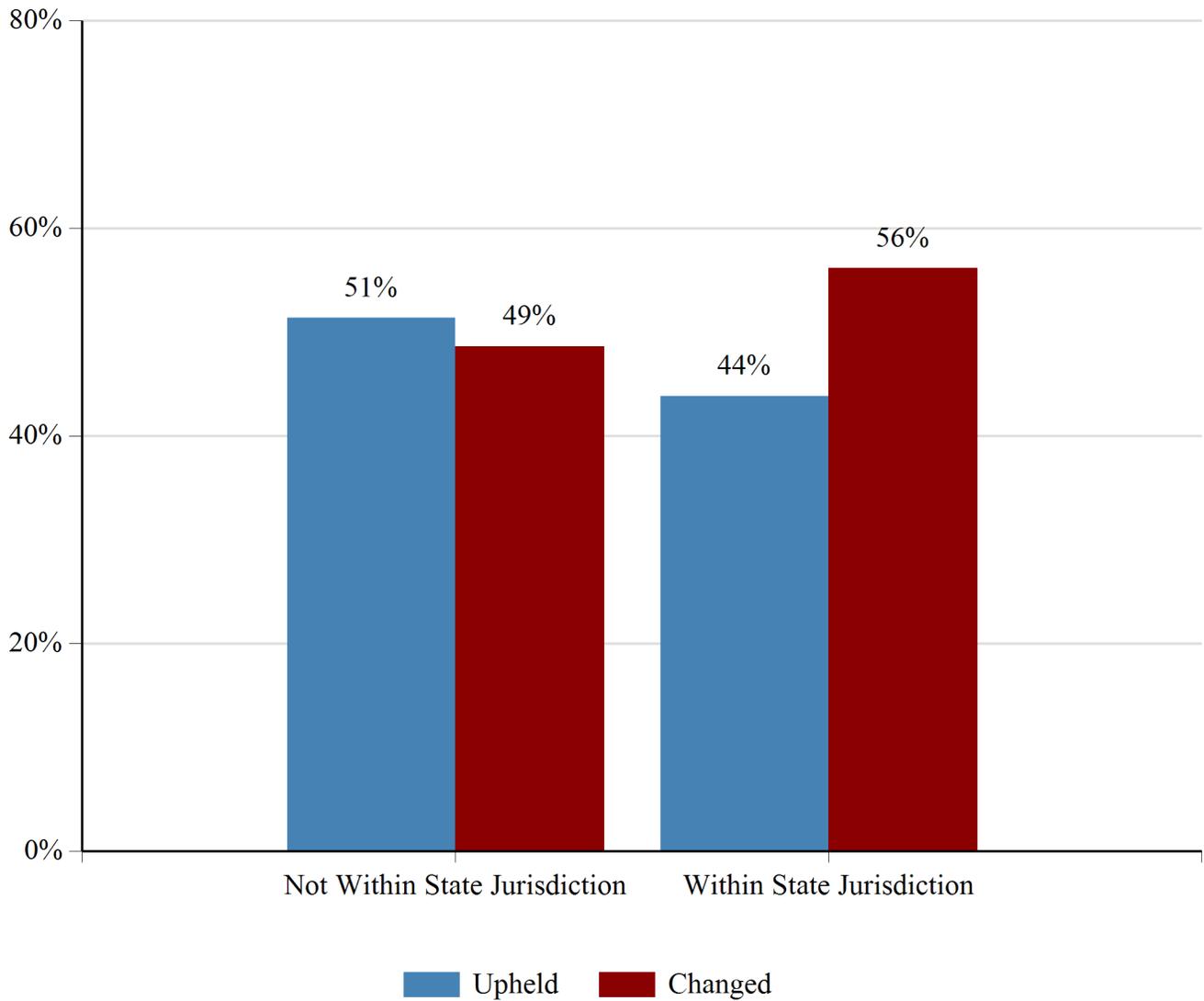
## HEAU Mediated Appeals and Grievances Cases Types of Carriers

The chart below identifies the types of carriers involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2014.



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

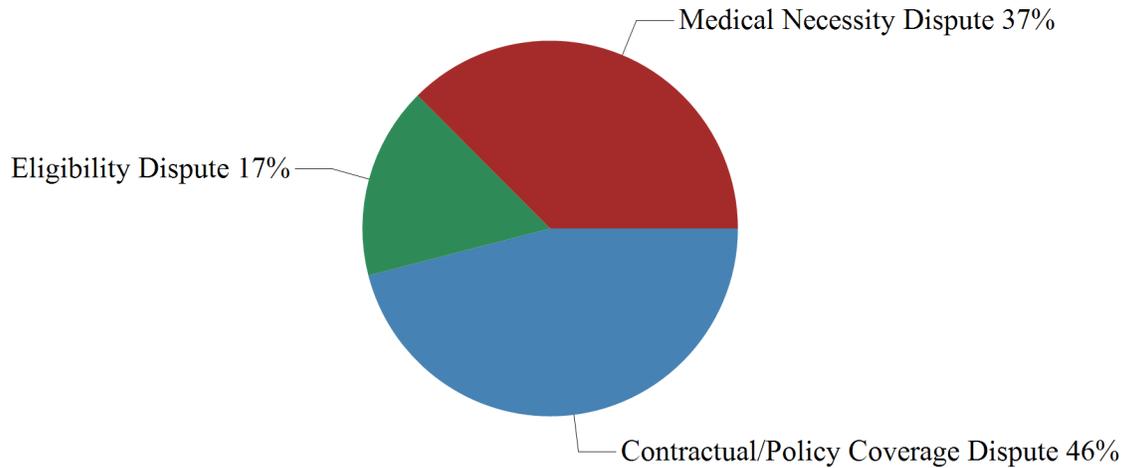
The chart below reflects the outcomes of Appeals and Grievances cases the HEAU mediated and closed during FY 2014 in relation to the MIA's regulatory authority over the carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



## HEAU Mediated Appeals and Grievances Cases

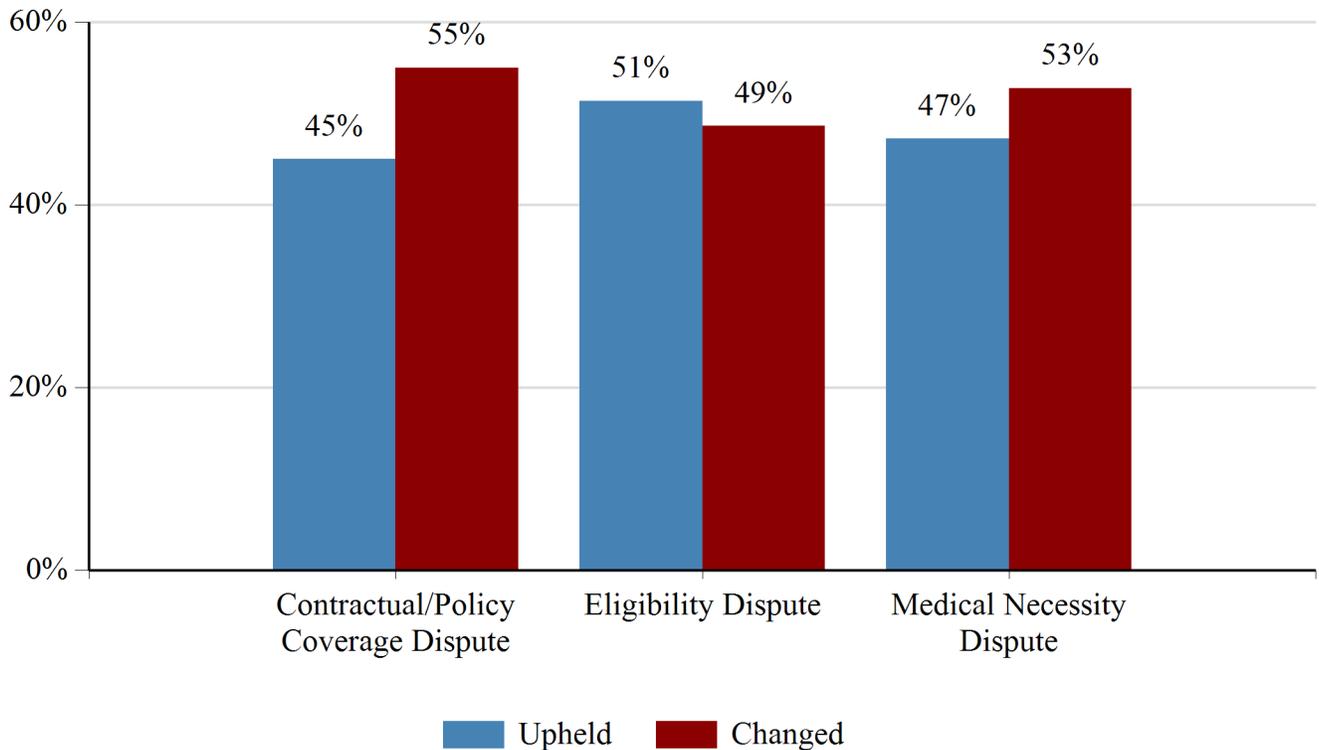
### Types of Denials

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 2014.



### Outcomes by Denial Type

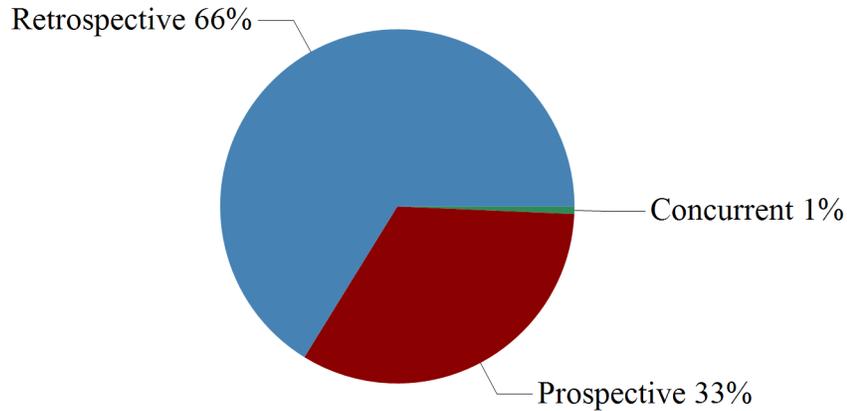
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes that the HEAU mediated and closed during FY 2014.



## HEAU Mediated Appeals and Grievances Cases

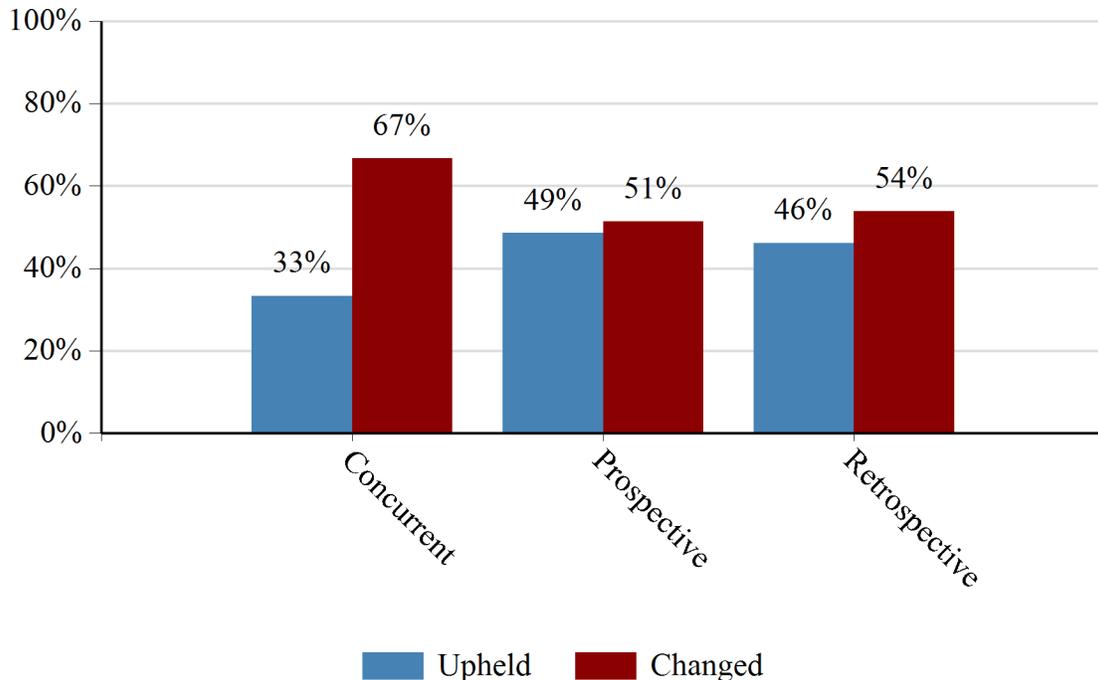
### Timing of Denials

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 2014. Eligibility denials are treated as prospective denials.



### Outcomes by Timing of Denials

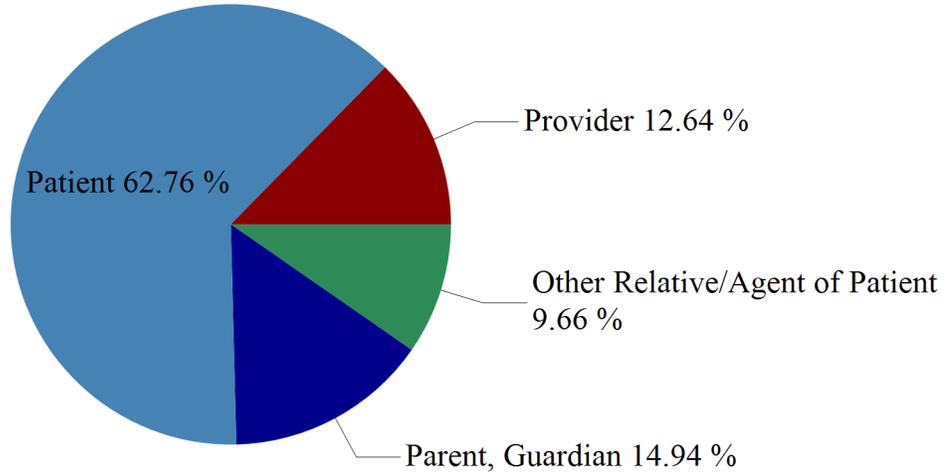
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2014 based on the timing of the decision.



## HEAU Mediated Appeals and Grievances Cases

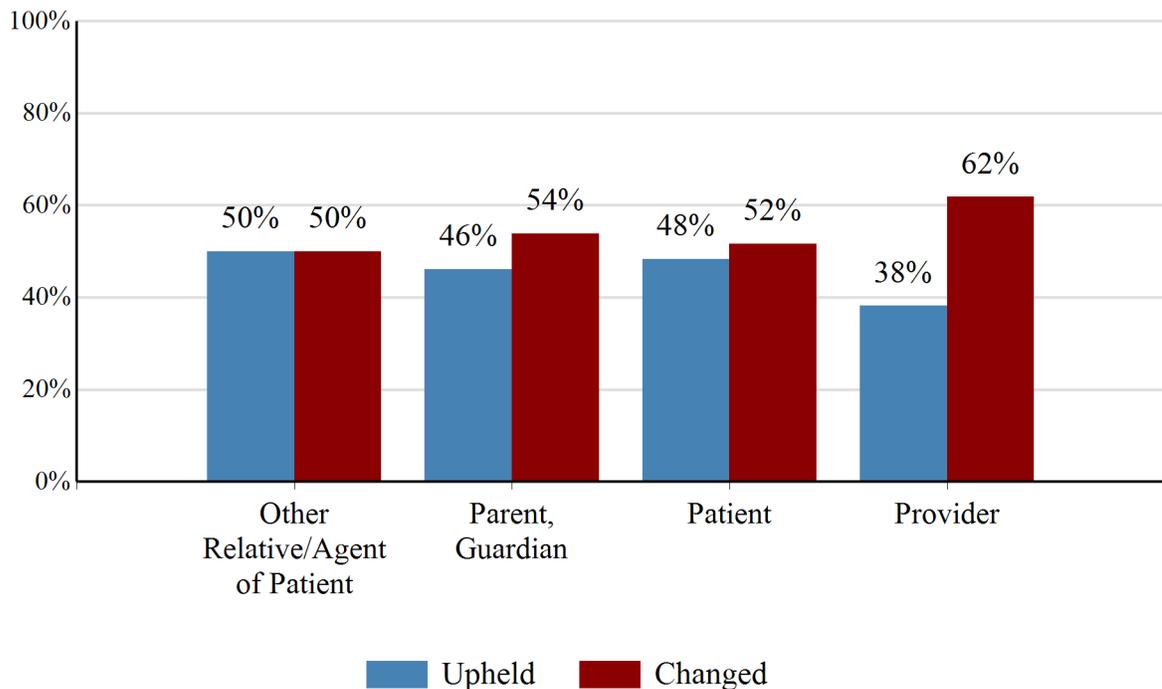
### Who Filed the Case

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 2014.



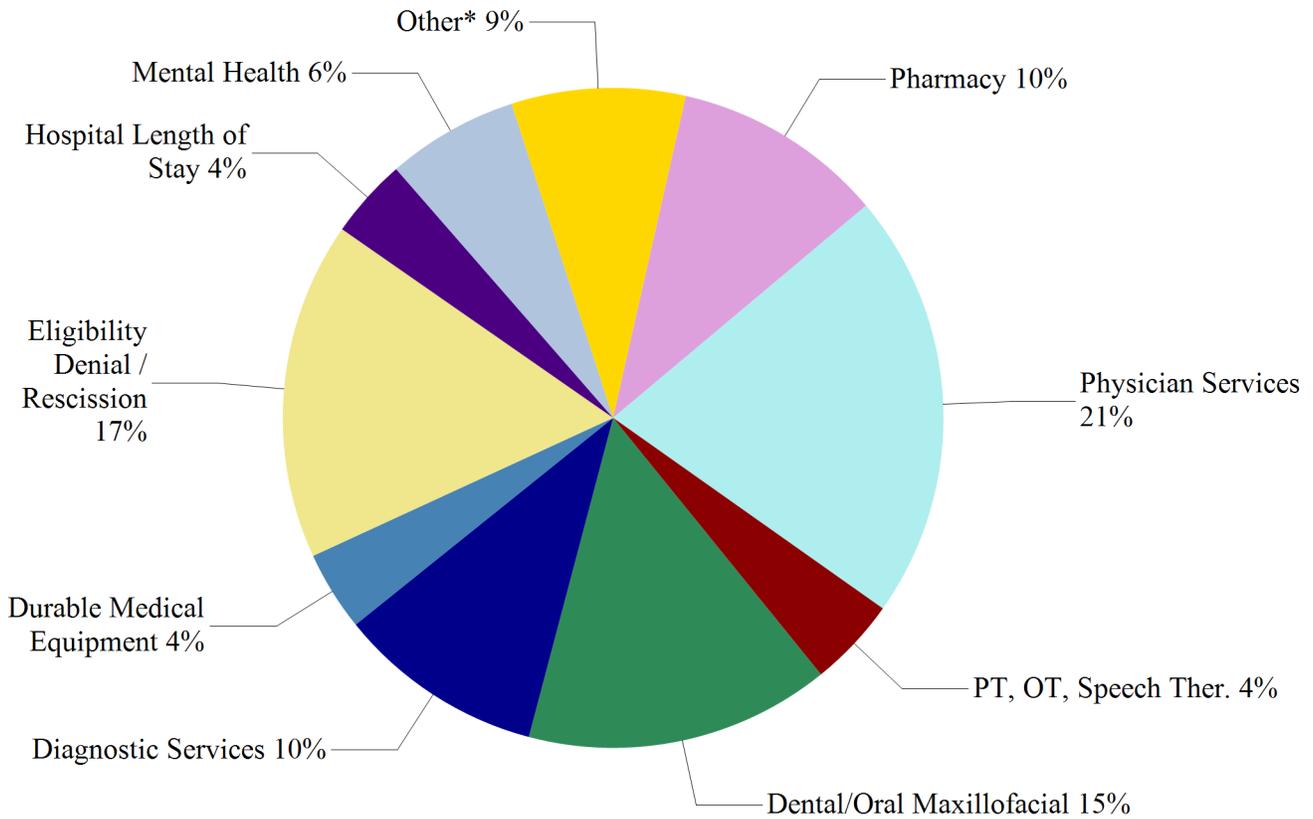
### Outcomes by Who Filed the Case

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 2014.



## HEAU Mediated Appeals and Grievances Cases Types of Services Denied

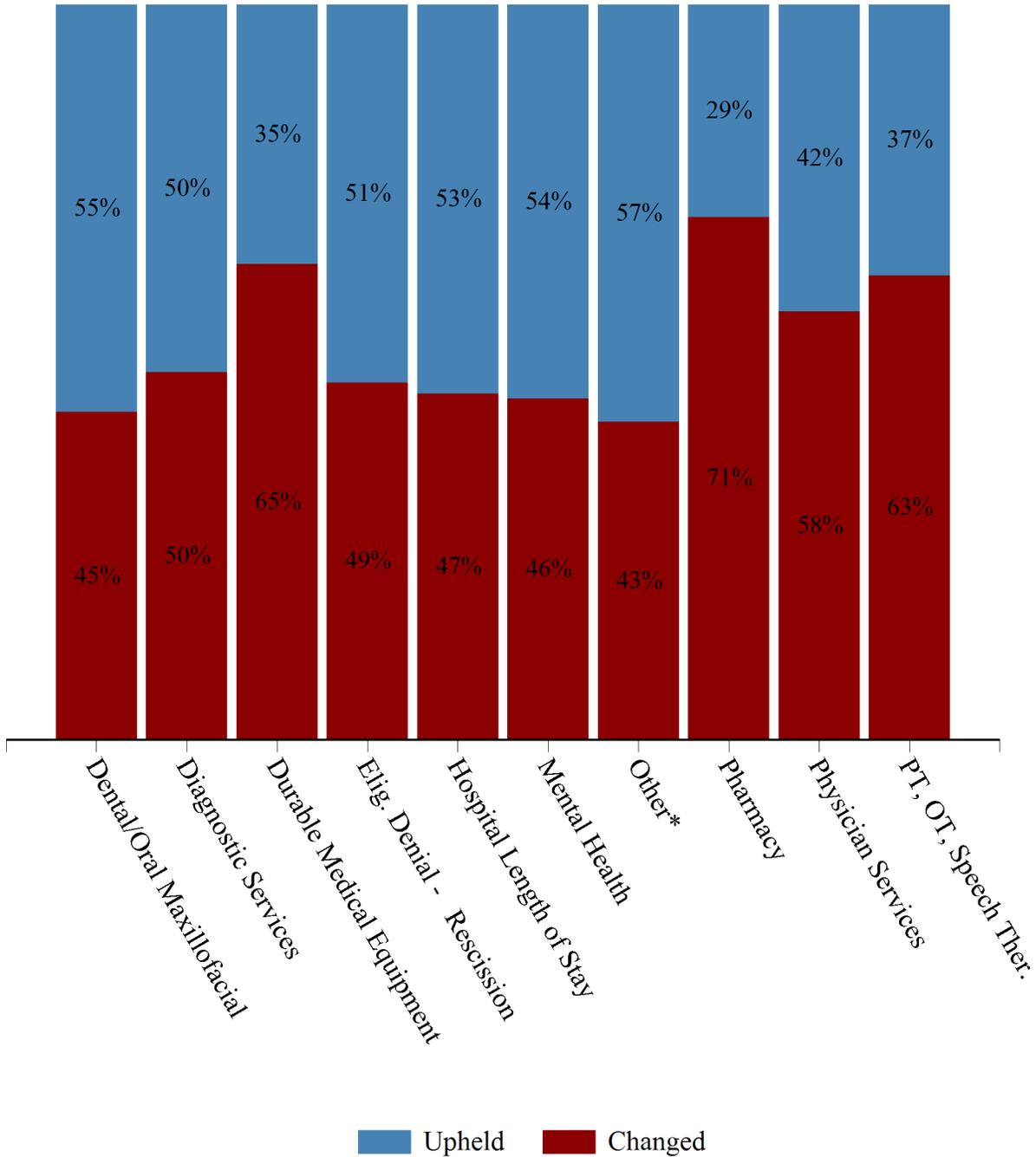
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2014.



\* "Other" includes acupuncture, chiropractic, emergency room, habilitative services, inpatient physical rehabilitation, podiatry, products and supplements, 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 2014 based on the type of services denied.



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