State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

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OFFICE OF THE ATTORNEY GENERAL

Submitted to the Governor and the General Assembly

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I. Executive Summary

The Health Education and Advocacy Unit (the "HEAU") of the Office of the Attorney General's Consumer Protection Division submits this annual report on the implementation of the Health Insurance Carrier Appeals and Grievances Law[1] (the "Appeals and Grievances Law") pursuant to 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 complaint and grievance processes 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 2011, beginning July 1, 2010 and concluding on June 30, 2011.

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, and (3) summarizes grievances and complaints handled by carriers, the MIA, and the HEAU.

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 establishes 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 health care claim. In 2011, the General Assembly enacted Chapters 3 and 4, each of which expanded the definition of "coverage decisions" to include a carrier's decision that someone is ineligible for coverage or that results in the rescission of an individual's coverage. As a result, effective July 1, 2011, patients in Maryland can

[1]Md. Code Ann., Insurance §15-10A-01 through §15-10A-09.
[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.

challenge any decision by a State-regulated plan that results in the total or partial denial of a health care claim, the denial of eligibility for coverage, or the rescission of coverage.[4]

As amended, the Appeals and Grievances Law established two very similar processes for patients to dispute carrier determinations, one for carriers' denials that proposed or delivered health care services are 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

The Patient Protection and Affordable Care Act (the "ACA") expanded the rights afforded to consumers. Under the expansion, consumers in plans previously unregulated by the MIA have the right to appeal health plans' decisions after March 23, 2010. Additional appeal rights were also added for Maryland consumers. For plan years beginning September 23, 2010, 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 medical judgment (including but not limited to those based on the plan's requirements for (a) medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), or (b) a rescission of coverage.

In 2011, the U.S. Department of Health and Human Services deemed the Maryland Appeals and Grievances Law to comply with federal law. Accordingly, Maryland continues to implement the Appeals and Grievance 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 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

[4] Since 2000, the HEAU has appealed eligibility denials and rescission of coverage cases on behalf of consumers and has reported these cases as contractual/coverage disputes. The data and statistics included in this report do not reflect specific categorization of eligibility denials or rescission appeals. Although the General Assembly passed legislation during FY 2011 reflecting these changes to the Appeals and Grievances Law, those changes did not become effective until July 1, 2011. The HEAU will include new categories of data to reflect these changes in its FY 2012 report. Similarly, Chapters 3 and 4 made other changes to processes and rights under the Appeals and Grievances Law that became effective July 1, 2011. These other changes will be addressed in the FY 2012 report as they became effective during FY 2012.

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 in matters involving urgent medical care.

After receiving the initial denial, the patient[5] may contest the determination through the carrier's internal grievance or appeal process. After receipt of the grievance or appeal, except in emergency circumstances,[6] 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 to the patient, the patient may file a complaint with the MIA or other external reviewer for an external review of the carrier's adverse decision or a coverage decision involving medical judgment. Other coverage decisions of carriers regulated by the MIA can be appealed to the MIA under the State law. The ACA did not extend external review rights for coverage decisions based strictly on contractual language unrelated to those 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 data provides 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*) carriers render.

- 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

[5]Throughout this report, we refer to the rights of patients during the appeals and grievances process. The Appeals and Grievances Law also gives health care providers the right to file appeals and grievances on behalf of their patients.

[6] Emergency cases require the rendering of a decision within 24 hours.

the limited data provides 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.

- Carriers are not required to report membership or enrollee numbers. Accordingly, the HEAU cannot analyze the proportion of adverse decisions and grievances as a reflection of the carrier's enrollment numbers.

Carrier Statistics FY 2011

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 86,778 adverse decisions in FY 2011, 451 fewer adverse decisions than reported in FY 2010. The carriers administratively reversed 298, or less than 0.4%, of the adverse decisions they issued.

2. Carriers reported that patients filed 9,572 internal grievances in FY 2011, a decrease of 314 grievances (3%) from FY 2010. As carriers are not required to report membership numbers, it cannot be determined if the decrease in grievances filed represents a decrease in overall membership.

3. Overall, during the internal grievance process, carriers altered their original adverse decisions in 68% of the grievances reported in FY 2011. Carriers overturned their adverse decisions in 49% of the grievances and modified their determinations in 19% of the grievances filed. This is consistent with the percentage of grievances carriers altered in FY 2010, when carriers reported changing 68% of their adverse decisions in the internal grievance process.

4. 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. However, there are two significant changes in the trends that are worth noting. First, the percentage of grievances carriers overturned or modified in FY 2011 increased significantly for laboratory and radiology services, durable medical equipment and pharmacy services. In FY 2011, carriers overturned or modified 44% of adverse decisions for durable medical equipment, 71% of adverse decisions for laboratory and radiology services, and 69% for pharmacy services, as compared to 22%, 29%, and 33%, respectively, in FY 2010. Second, the percentage of grievances carriers overturned or modified in FY 2011 decreased significantly from FY 2010 for home health services. Between FY 2010 and FY 2011, carriers decreased the percentage of grievances they overturned or modified for home health services from 64% to 20%.

5. 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 2011, carriers reported an overturned or modified rate of only 24% for mental health and substance abuse. This is consistent with the percentage of grievances carriers altered in FY 2010, when carriers reported changing 23% of grievances involving mental health/substance abuse adverse determinations.

V. Maryland Insurance Administration

The MIA has regulatory oversight of insurance products offered in Maryland. In enacting the Appeals and Grievances Law, the General Assembly gave the MIA the financial resources needed to handle the increased caseload and to retain medical experts to review the carriers' medical necessity adverse decisions. In addition to granting the MIA the specific authority to conduct external reviews, the Appeals and Grievances Law also describes the MIA's responsibilities and establishes deadlines for cases involving urgently needed care.

When the MIA receives a complaint, it reviews the complaint 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 carrier's internal grievance process has been fully exhausted. If not, the case is referred to the HEAU to assist the consumer through the carrier's internal grievance process. If the carrier's internal process has been exhausted or if there is a compelling reason to bypass the internal grievance process, the MIA has 5 working days after receipt of a complaint to contact the carrier in writing regarding the complaint and the carrier has 7 working days to respond to the MIA's written letter. The carrier may respond to the MIA by confirming or reversing its denial (administrative reversal) or by providing additional information related to the complaint.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law[7], an MIA investigator then prepares the case for review. The investigator contacts the appropriate parties in writing simultaneously and gives them a deadline for submitting additional documentation for consideration. Except for emergency cases that must be resolved within 24 hours of receipt of the initial complaint, the carrier must provide the MIA with all requested information within 7 working days from the date the carrier receives the request for information. Once the MIA investigator receives all of the documentation, the MIA reviews the file for non-medical necessity denials and, for medical necessity denials, the investigator forwards the file to medical experts at an IRO to provide the MIA with an opinion as to the medical necessity of the care. The MIA may accept and base the final decision on the complaint on the IRO's professional judgment.

In utilizing an IRO, the MIA ensures that the IRO has an appropriate board certified physician available to review the case. The IRO then transmits the case to its expert reviewer who reviews and researches the case, renders an opinion, and transmits the opinion to the IRO. The IRO, in turn, conducts a quality review of the expert reviewer's opinion. The IRO then informs the MIA of the expert reviewer's determination and provides the carrier with a copy of

[7] The HEAU also assists consumers with denials that are not subject to the Appeals and Grievances Law. The process for external review when the MIA is not the external reviewer varies. This report does not specifically address the process in those cases where the carrier is not subject to the Appeals and Grievances Law.

the IRO's opinion. If the IRO's determination is to reverse or modify the carrier's decision, the carrier is afforded the opportunity to do so before any administrative action is initiated (i.e. issuance of an administrative order). If after reviewing the IRO's decision, the carrier continues to uphold its position, the MIA will issue an order. In all instances, the carrier that is the subject of the complaint must pay the expense of the IRO selected by the Commissioner. The Commissioner must make a final decision on the complaint within 30 days after a complaint regarding pending health care services is filed and within 45 days after a complaint is filed regarding already-rendered health care services.[8] The Commissioner must issue a final decision on a complaint involving emergency care within 24 hours after the complaint is filed with the MIA. A hotline (800-492-6116) is available 24 hours a day, seven days a week to respond to these emergency cases.

If the reviewer's recommendation is to overturn the carrier's denial, and the MIA Commissioner agrees, a decision is issued and forwarded in writing to the carrier, along with a notice that the carrier has the right to request a hearing challenging the decision. The patient, patient's representative or provider who filed the complaint is notified of the outcome.

If the reviewer's recommendation is to uphold the carrier's denial, and the MIA Commissioner agrees, the patient or provider is informed of the decision and that they have the right to request a hearing. The carrier is also informed of this decision.

MIA Statistics FY 2011

Data reported by the MIA is reported on the charts and tables contained on pages 19-26 of this report. The data reflects 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 data reported by the MIA reveals:

1. The MIA's Appeals and Grievances Unit received 763 complaints in FY 2011. After reviewing these complaints, the MIA determined that 379 involved adverse decisions issued by State-regulated plans.

2. The MIA referred 72 complaints from State-regulated plans to the HEAU because the patient had not yet exhausted the carrier's internal grievance process.[9]

3. The MIA investigated 307 complaints in which patients challenged the adverse decision of their carrier. During the MIA's investigation, the carriers administratively reversed their adverse decisions in 165 (54%) of these cases. The remaining 142 cases the MIA forwarded to an IRO for external review.

4. Of the 142 cases the MIA forwarded to an IRO for external review, the MIA upheld 102 (72%) of the carrier decisions, overturned 24 (17%) of the decisions, and modified 16 (11%) of the decisions.

[8] The MIA can extend the 30- and 45- day periods for an additional 30 days to gather more information.
[9] The MIA also refers complaints from non-State regulated plans to the HEAU for possible assistance.

5. Of the 307 total cases in which the MIA initiated reviews of patients challenging their carriers' grievance decision, the carriers' decisions were reversed, overturned or modified 67% of the time.

VI. Health Education and Advocacy Unit

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 and/or coverage problems to other agencies, 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.

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 or coverage decision. The notice must also include the HEAU's address, telephone number (410-528-1840 or 877-261-8807), facsimile number (410-576-6571) and email address (heau@oag.state.md.us). The HEAU also conducts outreach programs to increase awareness of the rights and resources granted under the Appeals and Grievances Law.

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 provisions 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.[10] 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 appeals and grievances process, the carrier continues to deny coverage for the care, the patient may request that the HEAU prepare and file an external appeal of the carrier's decision with the MIA or other applicable external entity. The HEAU forwards the case to the MIA or other external entity with a copy of all relevant medical and insurance documentation.

[10] Md. Code Ann., Commercial Law §13-4A-02.

HEAU Statistics FY 2011

The HEAU data[11] is reported in the charts and tables contained on pages 27-41 of this report. The data reflects both medical necessity and contractual denials. Because newly filed cases contain incomplete data, the cases reported are those cases the HEAU closed during FY 2011.

The HEAU closed 1,536 cases in FY 2011. Of those 1,536 cases, 525 were appeals and grievances related cases. Not all of the 525 appeals and grievances cases filed with the HEAU were mediated. Many consumers, or other persons, file complaints but an authorization to release medical records form, which is required 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 525 appeals and grievances cases the HEAU closed during FY 2011, 363 or 69% involved assisting consumers with mediating or filing grievances of adverse or coverage decisions.

1. Of the 363 appeals and grievances cases the HEAU mediated during FY 2011, 233 (64%) related to MIA-regulated plans.

2. Of the 363 cases the HEAU mediated during FY 2011, 46% were adverse decisions (*medical necessity*) cases and 54% were coverage decisions (*contractual exclusion*) cases.

3. The HEAU mediation process resulted in the carrier overturning or modifying 57% of the adverse decision cases and 51% of the coverage decision cases.

4. In cases filed against carriers subject to MIA review, the HEAU mediation efforts resulted in carriers changing their decisions 67% of the time. For non-regulated plans, the HEAU efforts resulted in carriers changing their decisions 31% of the time.

5. In FY 2011, the HEAU assisted patients in recovering or saving more than $1.1 million, over $550,000 of which pertained to appeals and grievances cases. Since the Appeals and Grievances Law became effective in 1999, the HEAU has recovered or saved more than $19 million on behalf of patients, nearly $12 million of which pertains to appeals and grievances cases.

[11] 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.

VII. Appendix

Carrier Cases
Adverse Decisions, Grievances and Outcomes

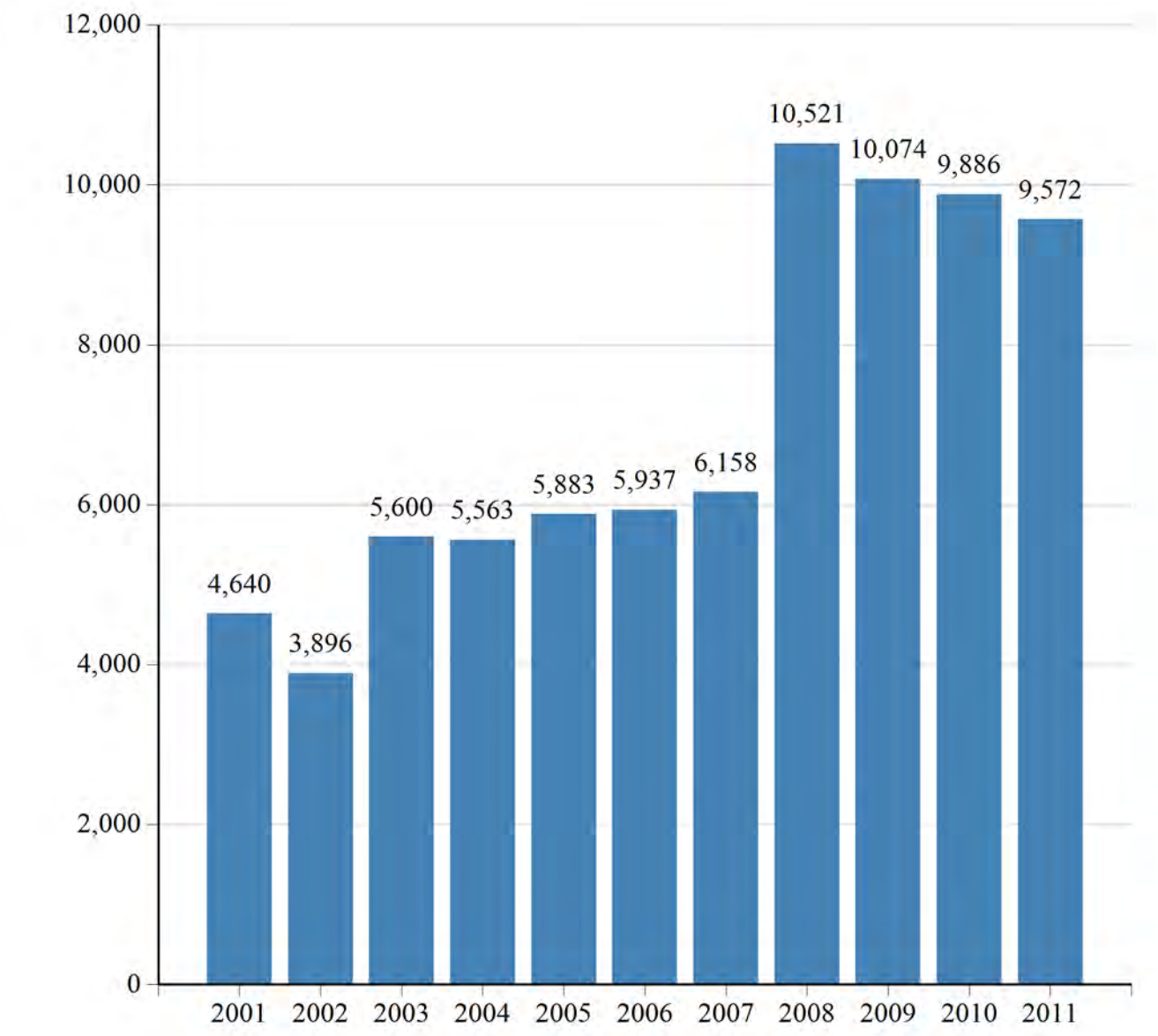
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Aetna Dental Inc.	393	0	1	0%	100%
Aetna Health Inc. (a Pennsylvania corporation)	864	43	51	55%	45%
Aetna Life Insurance Company	812	40	51	59%	41%
American General Life Insurance Company of Delaware	0	0	1	100%	0%
American Republic Insurance Company	1	0	1	100%	0%
Ameritas Life Insurance Corp.	168	0	27	48%	52%
CareFirst BlueChoice, Inc.	10,819	0	1,223	37%	63%
Carefirst of Maryland, Inc.	3,966	0	373	33%	67%
Cigna Dental Health of Maryland, Inc.	323	0	0	0%	0%
Cigna Healthcare of Mid-Atlantic, Inc.	20	0	2	100%	0%
Companion Life Insurance Company	2	0	0	0%	0%
Connecticut General Life Insurance Company	769	0	59	61%	39%
Coventry Health Care of Delaware, Inc.	2,193	66	370	62%	38%
Dental Benefit Providers of Illinois, Inc.	2,333	0	1,996	32%	68%
Fidelity Security Life Insurance Company	2	0	2	50%	50%
Golden Rule Insurance Company	7	0	7	57%	43%
Graphic Arts Benefit Corporation	1	1	1	0%	100%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Group Dental Service of Maryland, Inc.	32,565	0	378	32%	68%
Group Hospitalization and Medical Services, Inc.	7,170	1	518	31%	69%
Guardian Life Insurance Company of America	753	1	258	33%	67%
HumanaDental Insurance Company	43	3	7	71%	29%
John Alden Life Insurance Company	2	0	0	0%	0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	1,419	5	114	50%	50%
Kaiser Permanente Insurance Company	74	0	19	58%	42%
Lincoln National Life Insurance Company	16	0	0	0%	0%
Mamsi Life and Health Insurance Company	376	0	48	69%	31%
MD-Individual Practice Association, Inc.	2,168	0	812	32%	68%
Metropolitan Life Insurance Company	15,358	127	2,372	13%	87%
Optimum Choice, Inc.	1,609	2	375	41%	59%
Pan-American Life Insurance Company	0	0	4	100%	0%
Reliance Standard Life Insurance Company	19	0	6	67%	33%
Security Life Insurance Company of America	1	1	1	100%	0%
Standard Insurance Company	1	0	1	0%	100%
Standard Security Life Insurance Company of New York	0	0	11	82%	18%
The Dental Concern, Inc.	0	0	1	100%	0%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Time Insurance Company	8	1	1	100%	0%
Trustmark Life Insurance Company	1	0	0	0%	0%
Unicare Life & Health Insurance Company	6	0	4	50%	50%
Union Security Insurance Company	13	4	13	54%	46%
United Concordia Life and Health Insurance Company	1,044	0	202	38%	62%
United Healthcare Insurance Company	984	0	175	62%	38%
United Healthcare of the Mid-Atlantic, Inc.	475	3	83	81%	19%
United States Life Insurance Company In the City of New York	0	0	4	75%	25%
Total	**86,778**	**298**	**9,572**	**32%**	**68%**

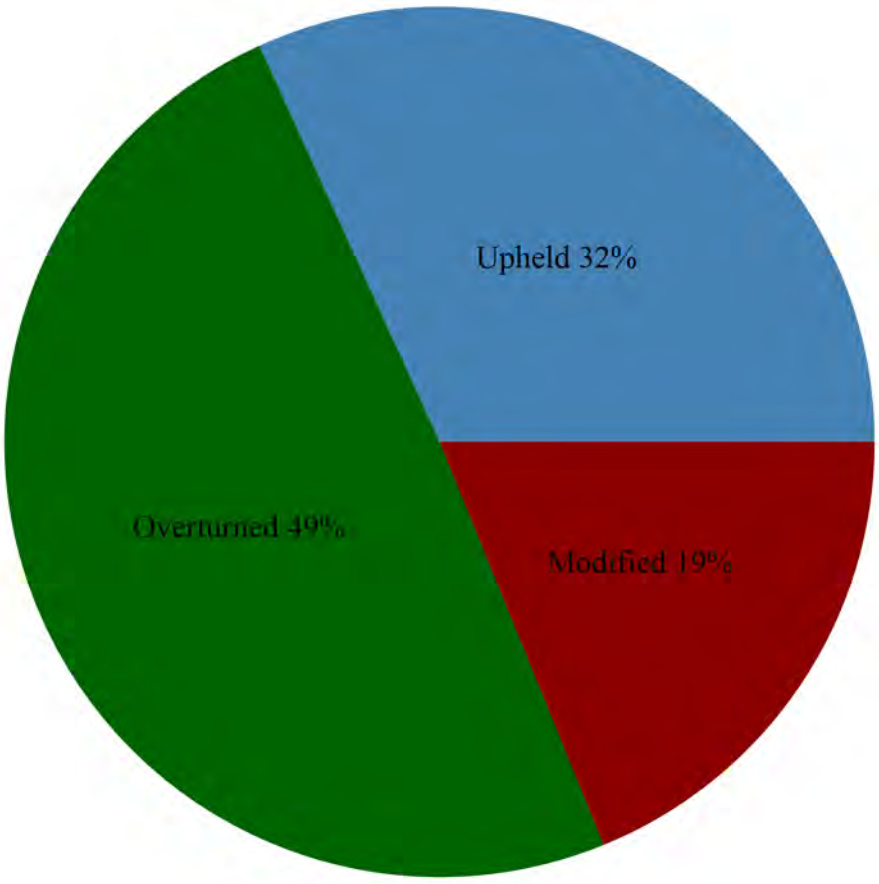
Carrier Grievances Cases
Number of Grievances Since 2001

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.



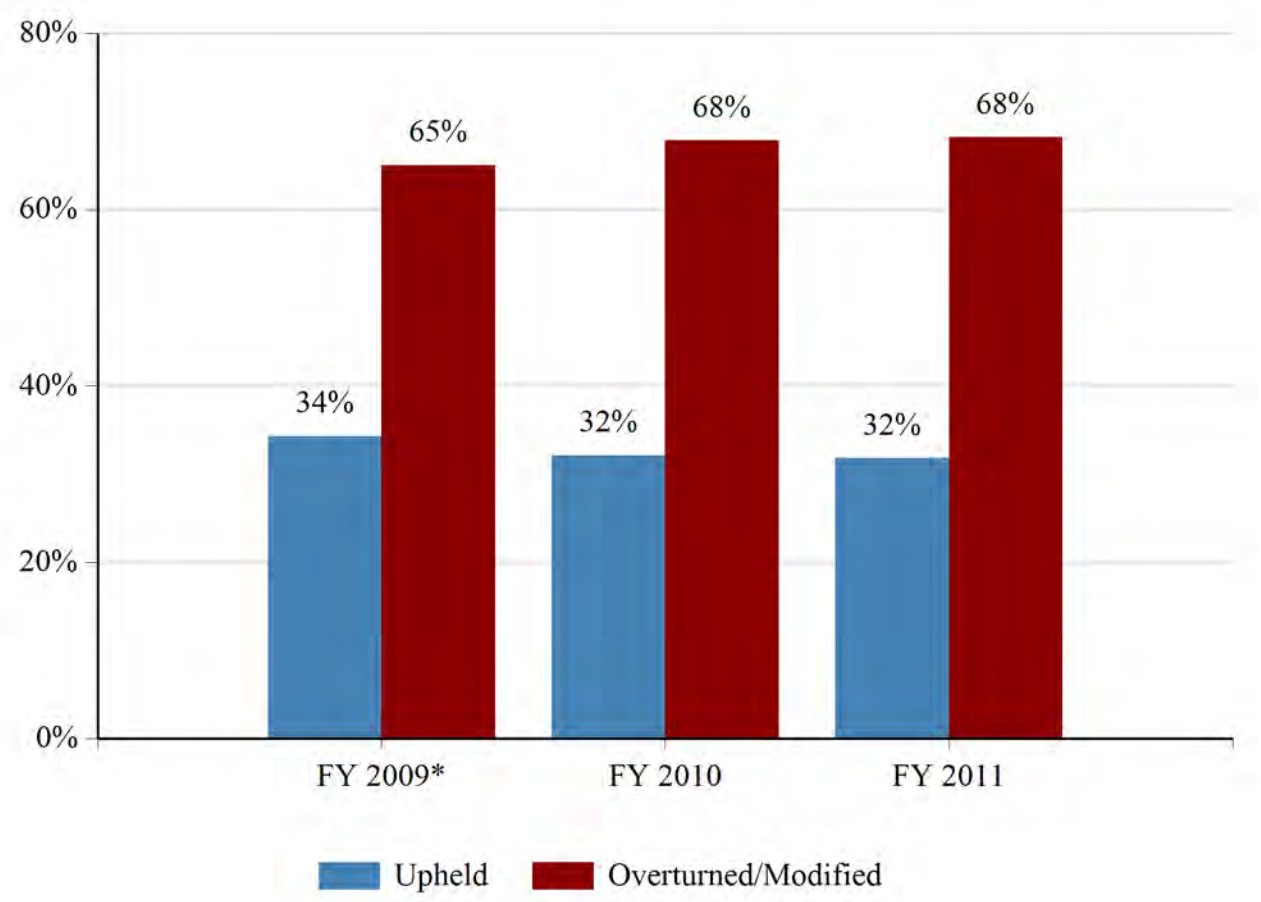
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 9,572 internal grievances filed with carriers in FY 2011, 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.



*For FY 2009, some carriers did not report the outcomes of all filed grievances. Accordingly, the outcomes in FY 2009 do not amount to 100% of the grievances filed.

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 2011, as reported by carriers. The carriers report mental health and substance abuse services together.

Type of Service	Adverse Decisions		Grievances	
Durable Medical Equipment	1,487	1.71%	183	1.91%
Emergency Room	480	0.55%	147	1.54%
Home Health	133	0.15%	15	0.16%
Inpatient Hospital	4,623	5.33%	958	10.01%
Laboratory, Radiology	5,154	5.94%	435	4.54%
Mental Health	637	0.73%	255	2.66%
Other*	180	0.21%	251	2.62%
Pharmacy	4,547	5.24%	642	6.71%
Physician	11,750	13.54%	1,191	12.44%
Podiatry, Dental, Optometry, Chiropractic	55,923	64.44%	5,398	56.39%
PT, OT, ST	1,738	2.00%	69	0.72%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	126	0.15%	28	0.29%
Total	**86,778**	**100%**	**9,572**	**100%**

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

Carrier Grievances Cases
Outcomes by Service Type

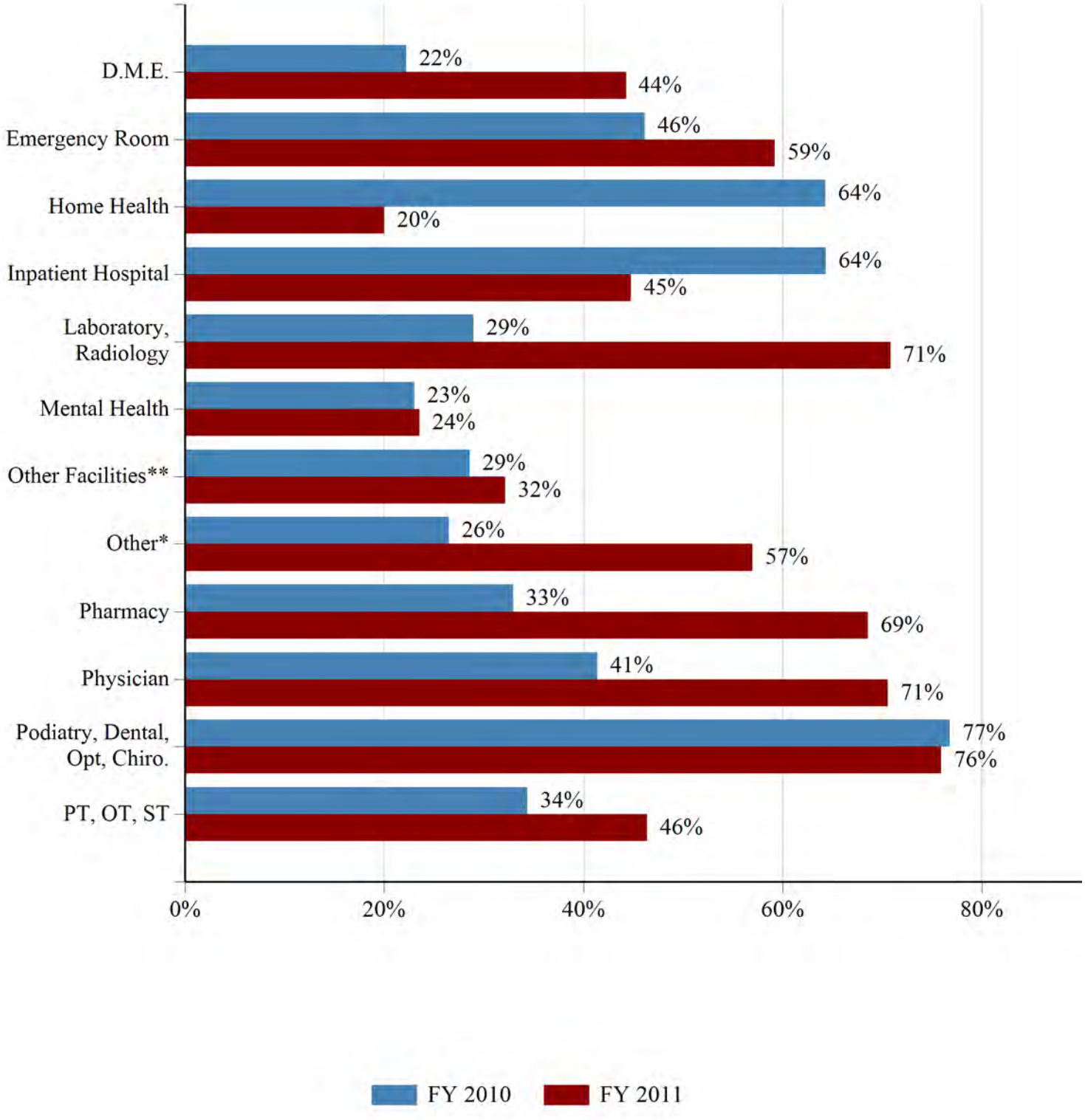
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Durable Medical Equipment	183	56%	44%
Emergency Room	147	41%	59%
Home Health	15	80%	20%
Inpatient Hospital	958	55%	45%
Laboratory, Radiology	435	29%	71%
Mental Health	255	76%	24%
Other*	251	43%	57%
Pharmacy	642	31%	69%
Physician	1191	29%	71%
Podiatry, Dental, Optometry, Chiropractic	5398	24%	76%
PT, OT, ST	69	54%	46%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	28	68%	32%
Total	**9,572**	**32%**	**68%**

*"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 2010 and FY 2011. The carriers report mental health and substance abuse services together.

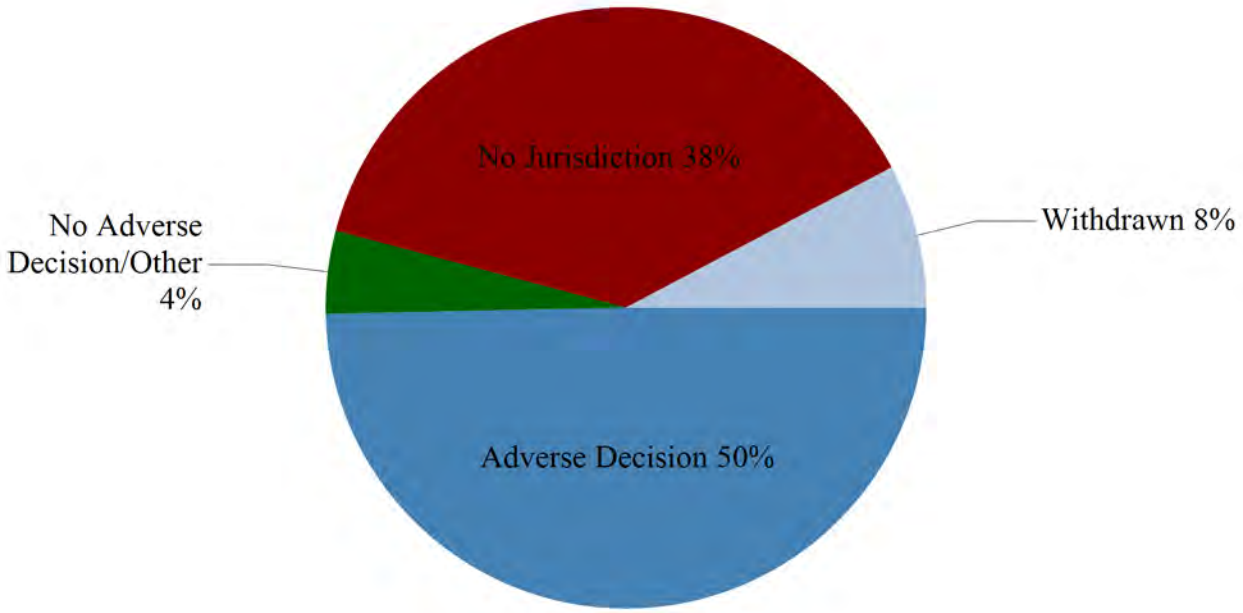


* "Other" means cases where the type of service did not fit an existing category.
**Other Facilities means Skilled Nursing, Sub Acute and Nursing Homes.

MIA Appeals and Grievances Complaints
Initial Review of Complaints

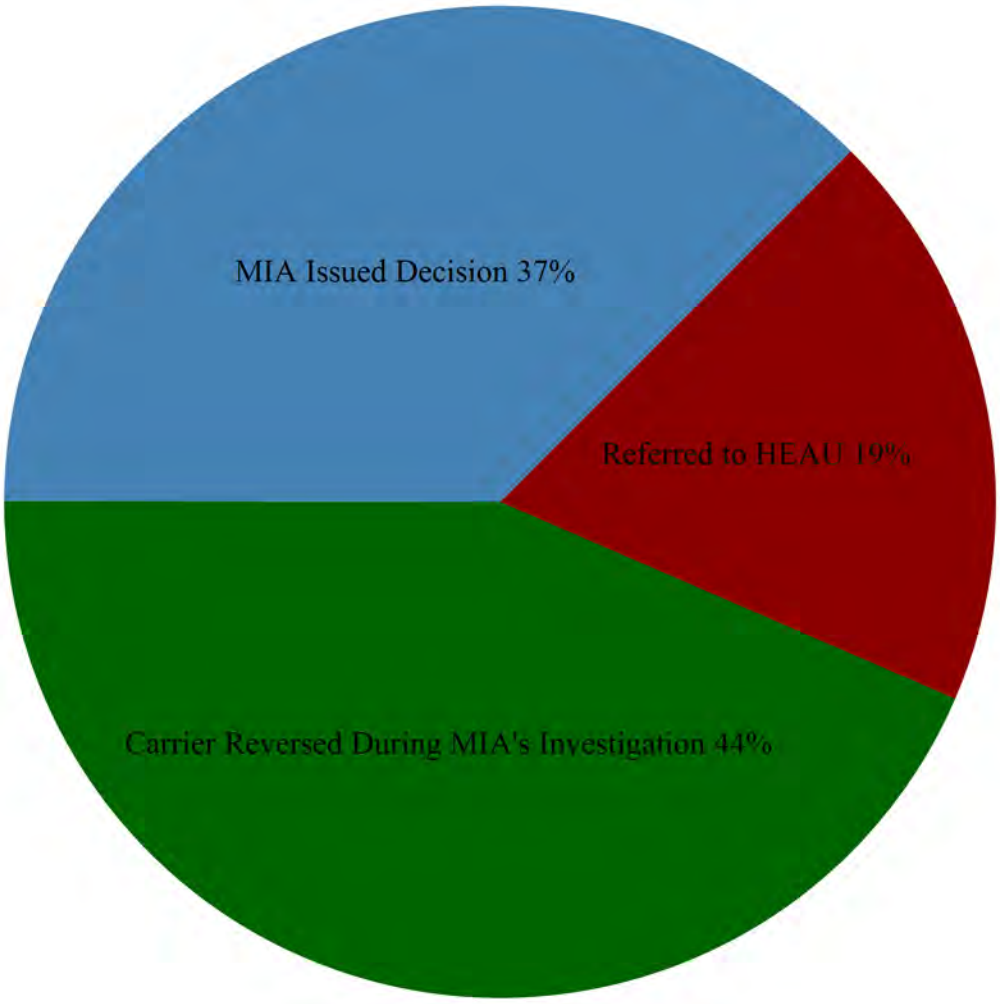
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some 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 763 complaints filed with the MIA's Appeals and Grievances Unit during FY 2011.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2011, the MIA determined that 379 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 72 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 379 grievances the MIA reviewed during FY 2011.



MIA Appeals and Grievances Cases
Carriers and Disposition

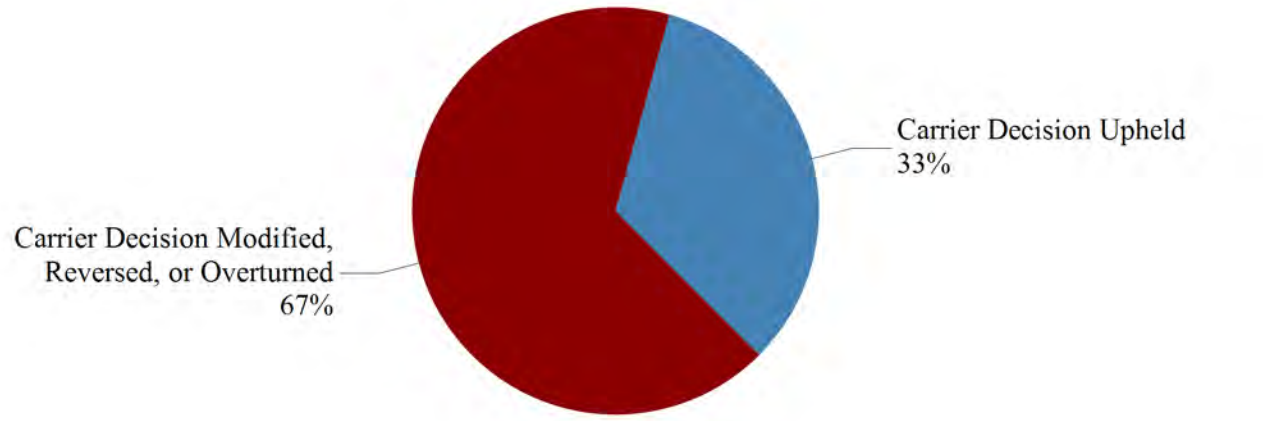
The table below details the outcomes of the 307 grievances complaints the MIA investigated during FY 2011. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	7	2	28.6%	1	14.3%	0	0.0%	4	57.1%
Aetna Health, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Aetna Life Insurance Company	12	4	33.3%	0	0.0%	0	0.0%	8	66.7%
American Republic Corp Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Anthem Blue Cross Blue Shield of New Hampshire	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
CareFirst BlueChoice, Inc.	58	17	29.3%	9	15.5%	3	5.2%	29	50.0%
Carefirst of Maryland, Inc.	21	6	28.6%	1	4.8%	2	9.5%	12	57.1%
Cigna Healthcare Mid-Atlantic, Incorporated	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
Connecticut General Life Insurance Company	6	2	33.3%	0	0.0%	0	0.0%	4	66.7%
Coventry Health and Life Insurance Company	8	4	50.0%	1	12.5%	1	12.5%	2	25.0%
Coventry Health Care of Delaware, Inc.	39	10	25.6%	4	10.3%	5	12.8%	20	51.3%
Graphic Arts Benefit Corporation	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Group Dental Service of Maryland, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Group Hospitalization and Medical Services, Inc.	25	14	56.0%	4	16.0%	1	4.0%	6	24.0%
Guardian Life Insurance Company of America	5	3	60.0%	0	0.0%	0	0.0%	2	40.0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	10	4	40.0%	0	0.0%	0	0.0%	6	60.0%

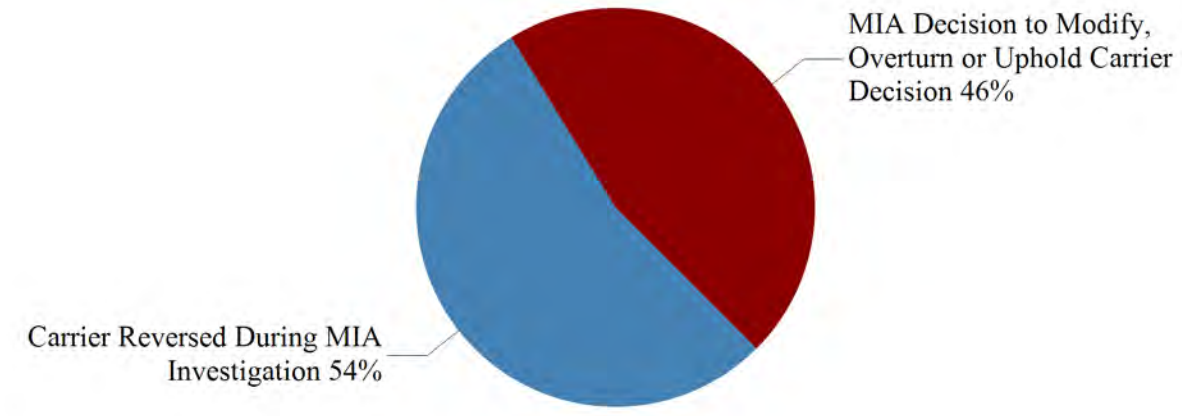
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Kaiser Permanente Insurance Company	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
Mamsi Life and Health Insurance Company	6	3	50.0%	0	0.0%	0	0.0%	3	50.0%
Maryland Health Insurance Plan	12	0	0.0%	1	8.3%	0	0.0%	11	91.7%
MD-Individual Practice Association, Inc.	1	0	0.0%	0	0.0%	1	100.0%	0	0.0%
Metropolitan Life Insurance Company	9	0	0.0%	0	0.0%	1	11.1%	8	88.9%
Optimum Choice, Inc.	30	16	53.3%	1	3.3%	2	6.7%	11	36.7%
United Concordia Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
United Concordia Life and Health Insurance Company	8	1	12.5%	1	12.5%	0	0.0%	6	75.0%
United Healthcare Insurance Company	33	12	36.4%	1	3.0%	0	0.0%	20	60.6%
United Healthcare of the Mid-Atlantic, Inc.	7	1	14.3%	0	0.0%	0	0.0%	6	85.7%
Total	**307**	**102**	**33%**	**24**	**8%**	**16**	**5%**	**165**	**54%**

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 307 grievances the MIA investigated.

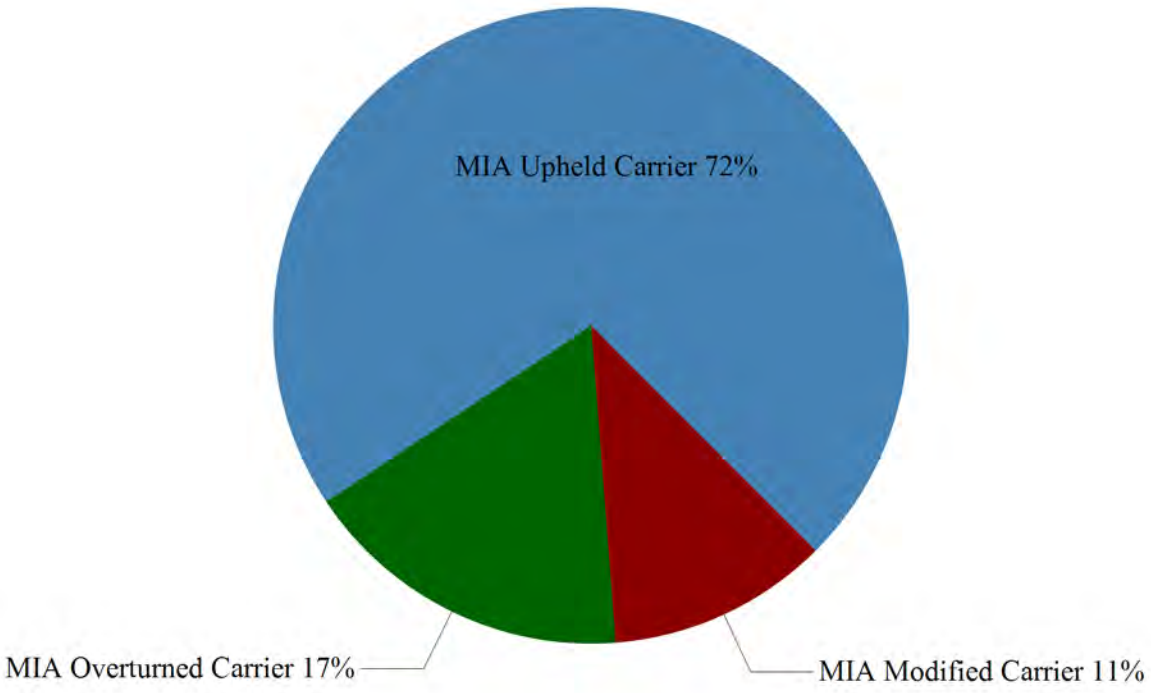


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of those 142 cases the MIA forwarded to an IRO for review in FY 2011



MIA Appeals and Grievances Cases
Types of Services Denied and Outcomes

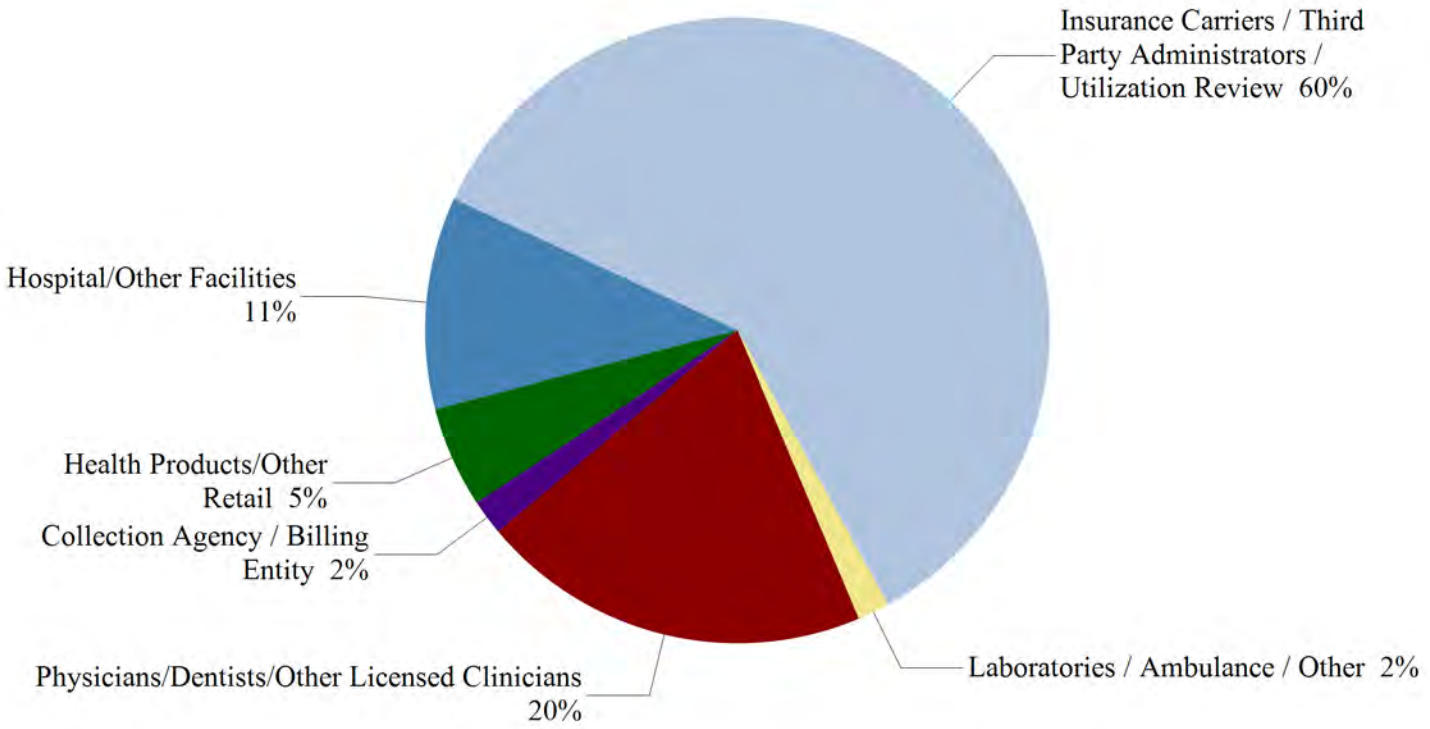
The table below identifies the types of services involved in grievances the MIA investigated during the fiscal year. It shows how the outcome varies based on the types of services involved in the grievances.

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Acupuncture	1	0%	0	0%	0	0%	0	0%	1	100%
Chiropractic Care Services	1	0%	1	100%	0	0%	0	0%	0	0%
Cosmetic	5	2%	2	40%	0	0%	0	0%	3	60%
Denial of Claim	2	1%	1	50%	0	0%	0	0%	1	50%
Denial of Hospital Days	51	17%	23	45%	6	12%	5	10%	17	33%
Dental Care Services	31	10%	6	19%	2	6%	3	10%	20	65%
Durable Medical Equipment	15	5%	5	33%	2	13%	1	7%	7	47%
Emergency Room Denial	4	1%	1	25%	0	0%	0	0%	3	75%
Emergency Treatment Denial	4	1%	1	25%	0	0%	0	0%	3	75%
Experimental	29	9%	13	45%	5	17%	0	0%	11	38%
Habilitative Service	1	0%	0	0%	1	100%	0	0%	0	0%
Home Care Services	2	1%	1	50%	0	0%	0	0%	1	50%
In-Patient Rehabilitation Services	1	0%	0	0%	0	0%	1	100%	0	0%
Lab, Imaging, Test Services	10	3%	3	30%	0	0%	0	0%	7	70%
Mental Health Partial Hospitalization	3	1%	0	0%	0	0%	0	0%	3	100%
Mental Health/Substance Abuse (Inpatient) Services	32	10%	14	44%	0	0%	3	9%	15	47%
Mental Health/Substance Abuse (Outpatient) Services	2	1%	1	50%	0	0%	0	0%	1	50%
No Preauthorization	2	1%	0	0%	0	0%	0	0%	2	100%
Nursing Home Services	1	0%	1	100%	0	0%	0	0%	0	0%
Other	1	0%	0	0%	0	0%	1	100%	0	0%
Out-of-Network Benefits	2	1%	1	50%	0	0%	0	0%	1	50%

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Outpatient Services	1	0%	0	0%	0	0%	0	0%	1	100%
PCP Referrals	1	0%	0	0%	0	0%	0	0%	1	100%
Pharmacy Services/Formulary Issues	64	21%	11	17%	7	11%	1	2%	45	70%
Physician Services	32	10%	12	38%	1	3%	1	3%	18	56%
Podiatry Services	1	0%	1	100%	0	0%	0	0%	0	0%
PT, OT, ST Services	6	2%	4	67%	0	0%	0	0%	2	33%
Transportation Services	2	1%	0	0%	0	0%	0	0%	2	100%
Total	**307**	**100%**	**102**	**33%**	**24**	**8%**	**16**	**5%**	**165**	**54%**

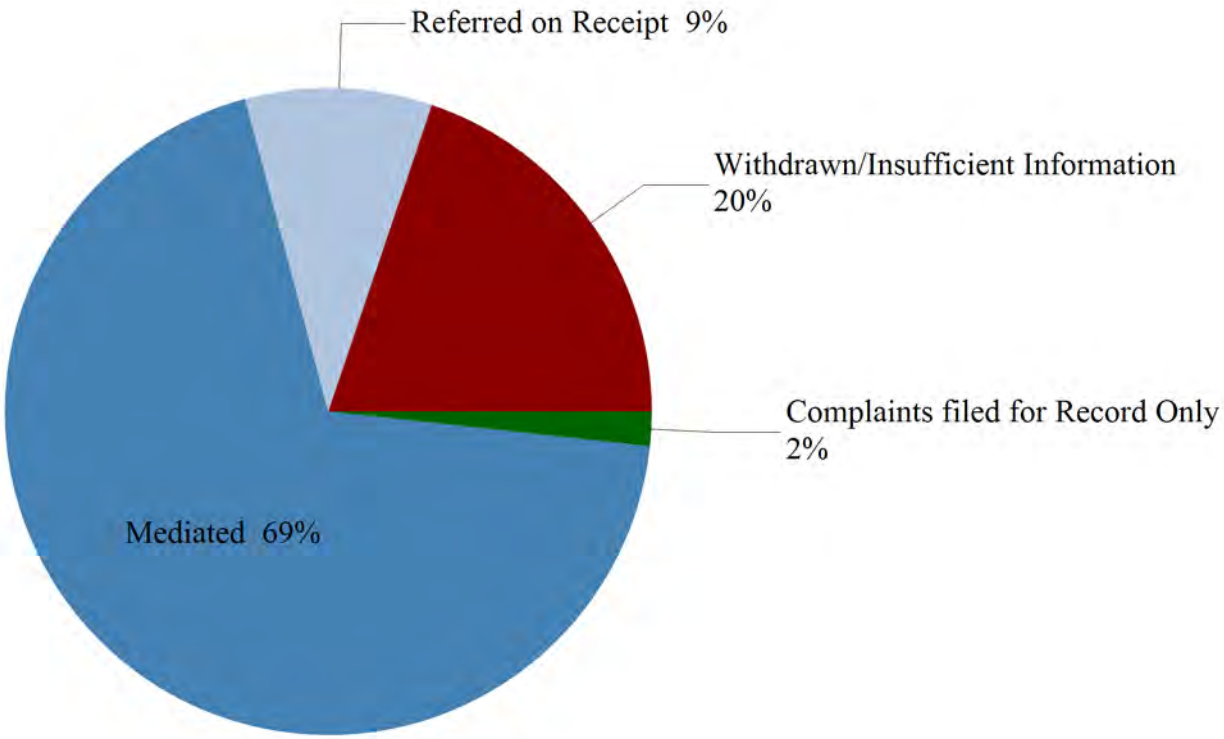
HEAU Cases
Subject of Complaints

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. The chart below shows the types of industries involved in the cases the HEAU closed during the fiscal year. The HEAU closed 1,536 complaints. Some complaints were filed against more than one industry.



HEAU Appeals and Grievances Cases
Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Many 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 2011.



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 2011. 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 2011.

Carrier	Total Complaints	Upheld		Overturned/Modified	
Aetna US Healthcare					
State Regulated	11	7	64%	4	36%
Not State Regulated	15	14	93%	1	7%
Total Complaints	**26**	**21**	**81%**	**5**	**19%**
Anthem Blue Cross Blue Shield					
State Regulated	1	0	0%	1	100%
Not State Regulated	2	2	100%	0	0%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Anthem UM Services					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
APS Healthcare					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
APS Healthcare Bethesda, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Assurant Health					
State Regulated	3	0	0%	3	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
Blue Cross Blue Shield of Georgia					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield of Maryland					
State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Blue Cross Blue Shield of Texas					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CareFirst					
State Regulated	68	21	31%	47	69%
Not State Regulated	36	22	61%	14	39%
Total Complaints	**104**	**43**	**41%**	**61**	**59%**

Carrier	Total Complaints	Upheld		Overturned/Modified	
Carefirst BlueChoice					
State Regulated	41	10	24%	31	76%
Not State Regulated	5	2	40%	3	60%
Total Complaints	**46**	**12**	**26%**	**34**	**74%**
CareFirst BlueCross BlueShield					
State Regulated	4	2	50%	2	50%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**
Caremark Prescription Service					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
CIGNA					
State Regulated	4	1	25%	3	75%
Not State Regulated	3	3	100%	0	0%
Total Complaints	**7**	**4**	**57%**	**3**	**43%**
Coventry Health Care					
State Regulated	8	2	25%	6	75%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**9**	**3**	**33%**	**6**	**67%**
Delta Dental of Pennsylvania					
State Regulated	1	0	0%	1	100%
Not State Regulated	2	2	100%	0	0%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Denex Dental					
State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Dental Benefit Providers, Inc.					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Empire Blue Cross Blue Shield					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Excellus Blue Cross Blue Shield					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Golden Rule Insurance					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Guardian Life Insurance Company of America					
State Regulated	3	3	100%	0	0%
Total Complaints	**3**	**3**	**100%**	**0**	**0%**

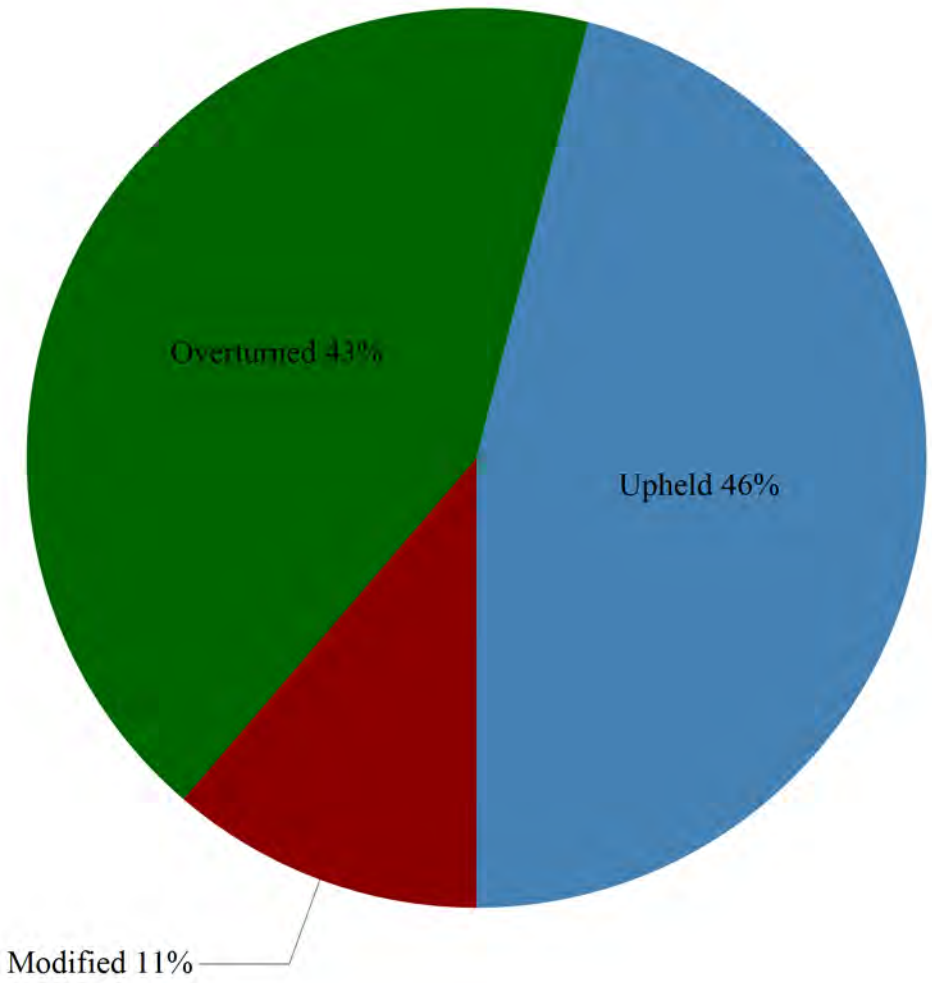
Carrier	Total Complaints	Upheld		Overturned/Modified	
HealthSpring					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Highmark Blue Shield					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Hines and Associates					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
InforMed, LLC					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Kaiser Permanente					
State Regulated	10	7	70%	3	30%
Not State Regulated	6	4	67%	2	33%
Total Complaints	**16**	**11**	**69%**	**5**	**31%**
Kaiser Permanente Insurance Company					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
LBA Healthplans, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Magellan Behavioral Health					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
MAMSI Life & Health Insurance Company					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Maryland Health Insurance Plan (MHIP)					
State Regulated	5	3	60%	2	40%
Total Complaints	**5**	**3**	**60%**	**2**	**40%**
MDIPA					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Medco Health Solutions, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Complaints	Upheld		Overturned/Modified	
Medical Benefits Administrators					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Medicare					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
MetLife					
State Regulated	24	2	8%	22	92%
Not State Regulated	6	2	33%	4	67%
Total Complaints	**30**	**4**	**13%**	**26**	**87%**
MHNet Behavioral Health					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
National Capital Administrative Services					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
National Elevator Industry Health Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
NCAS					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
OneNet PPO					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Optimum Choice					
State Regulated	4	1	25%	3	75%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**5**	**2**	**40%**	**3**	**60%**
Security Life Insurance Company of America					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
United Behavioral Health					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
United Concordia Companies, Inc.					
State Regulated	15	6	40%	9	60%
Not State Regulated	11	8	73%	3	27%
Total Complaints	**26**	**14**	**54%**	**12**	**46%**

Carrier	Total Complaints	Upheld		Overturned/Modified	
United Healthcare					
State Regulated	20	7	35%	13	65%
Not State Regulated	18	13	72%	5	28%
Total Complaints	**38**	**20**	**53%**	**18**	**47%**
United Medical Resources					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Totals					
State Regulated	235	78	33.2%	157	66.8%
Not State Regulated	130	90	69.2%	40	30.8%
TOTALS	**365**	**168**	**46%**	**197**	**54%**

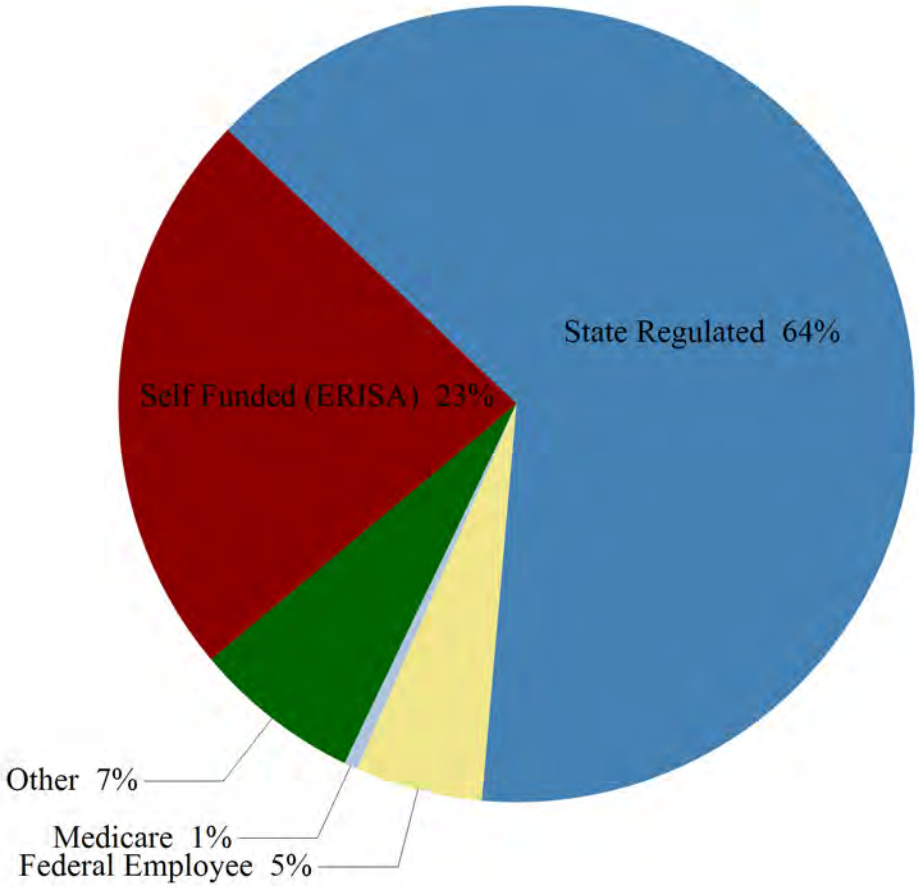
HEAU Appeals and Grievances Cases
Disposition

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 2011.



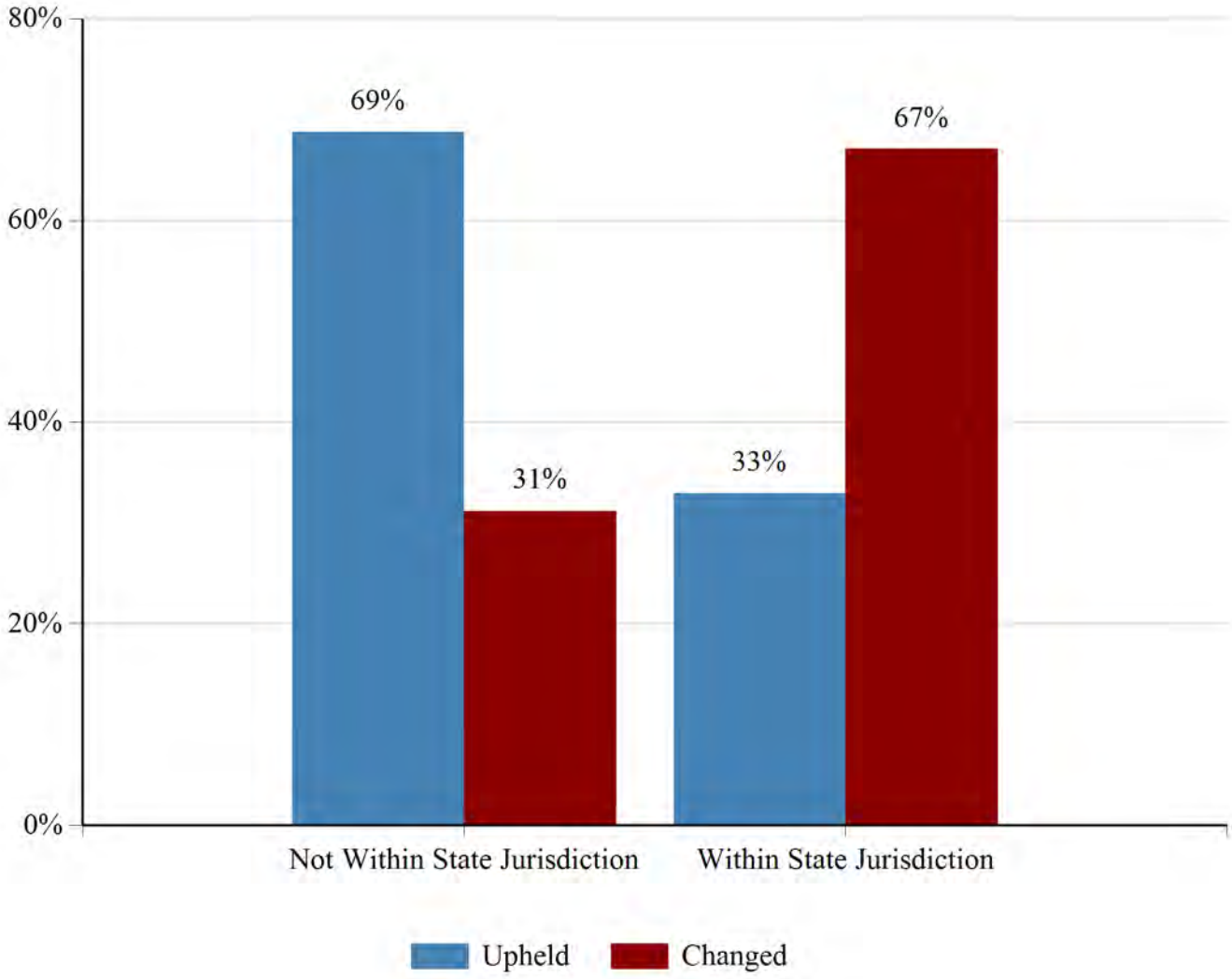
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the types of carriers involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2011.



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

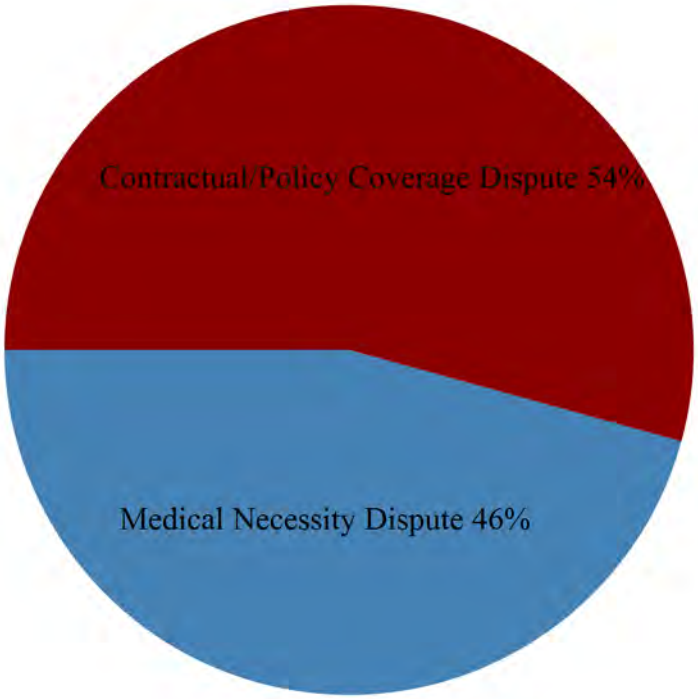
The chart below reflects the outcomes of Appeals and Grievances cases the HEAU mediated and closed during FY 2011 in relation to the MIA's regulatory authority over the carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

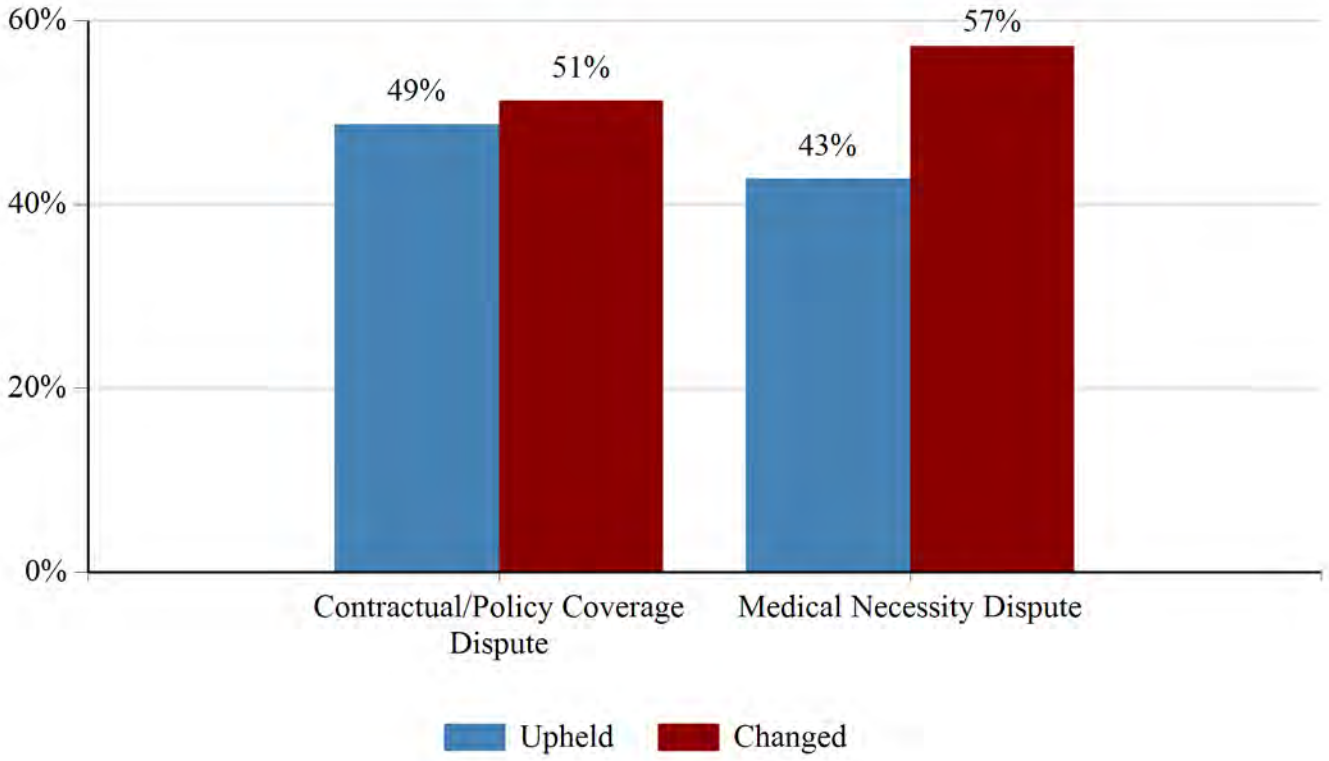
Types of Denials

The HEAU reports data on medical necessity denials and contractual coverage disputes. The chart below identifies the percentages of each type of case the HEAU mediated and closed during FY 2011.



Outcomes by Denial Type

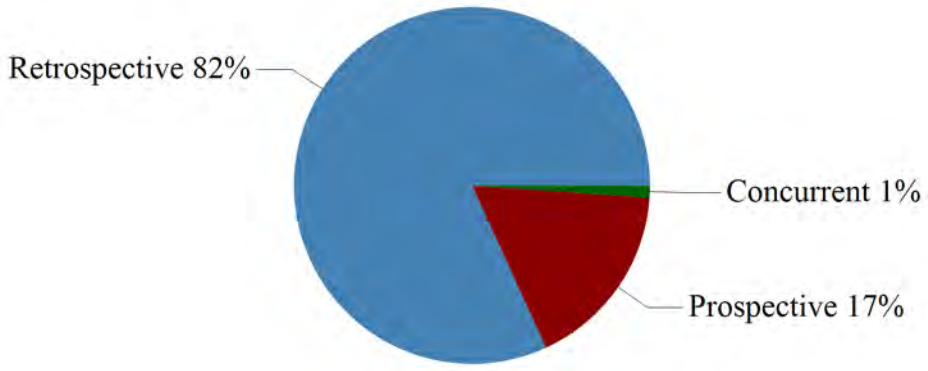
The chart below compares the outcomes of medical necessity and contractual coverage disputes that the HEAU mediated and closed during FY 2011.



HEAU Mediated Appeals and Grievances Cases

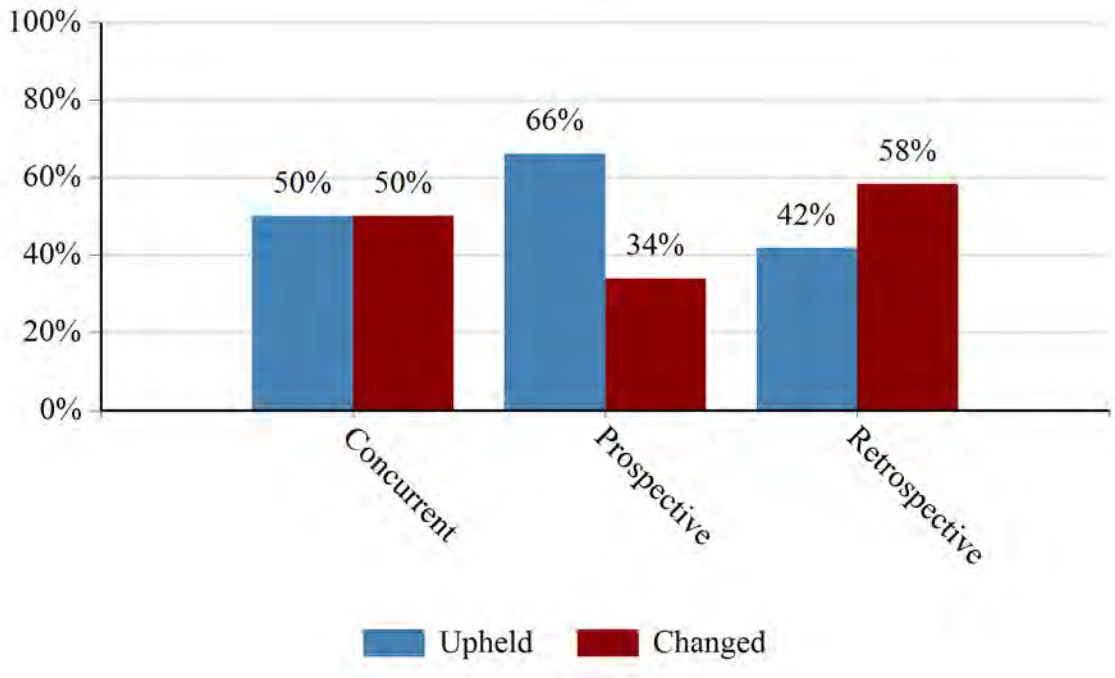
Timing of Denials

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 2011.



Outcomes by Timing of Denials

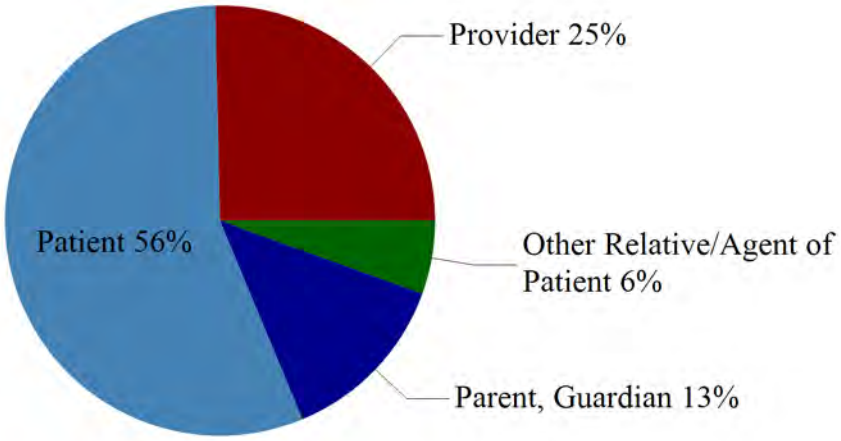
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2011 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

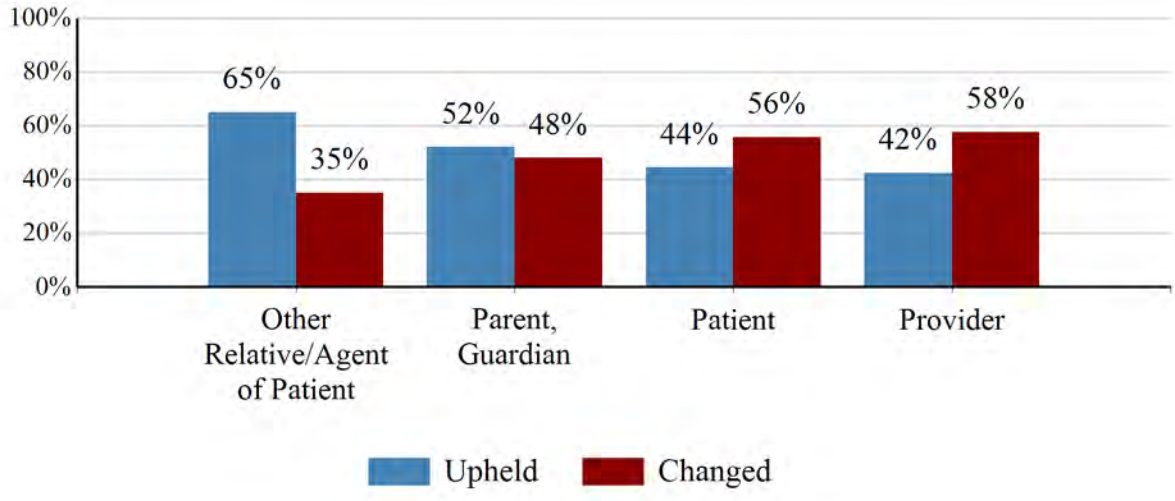
Who Filed the Case

Complaints may be filed by patients or filed on behalf of patients by providers, parents, relatives, or other agents. The chart below shows who filed mediated Appeals and Grievances cases the HEAU closed during FY 2011.



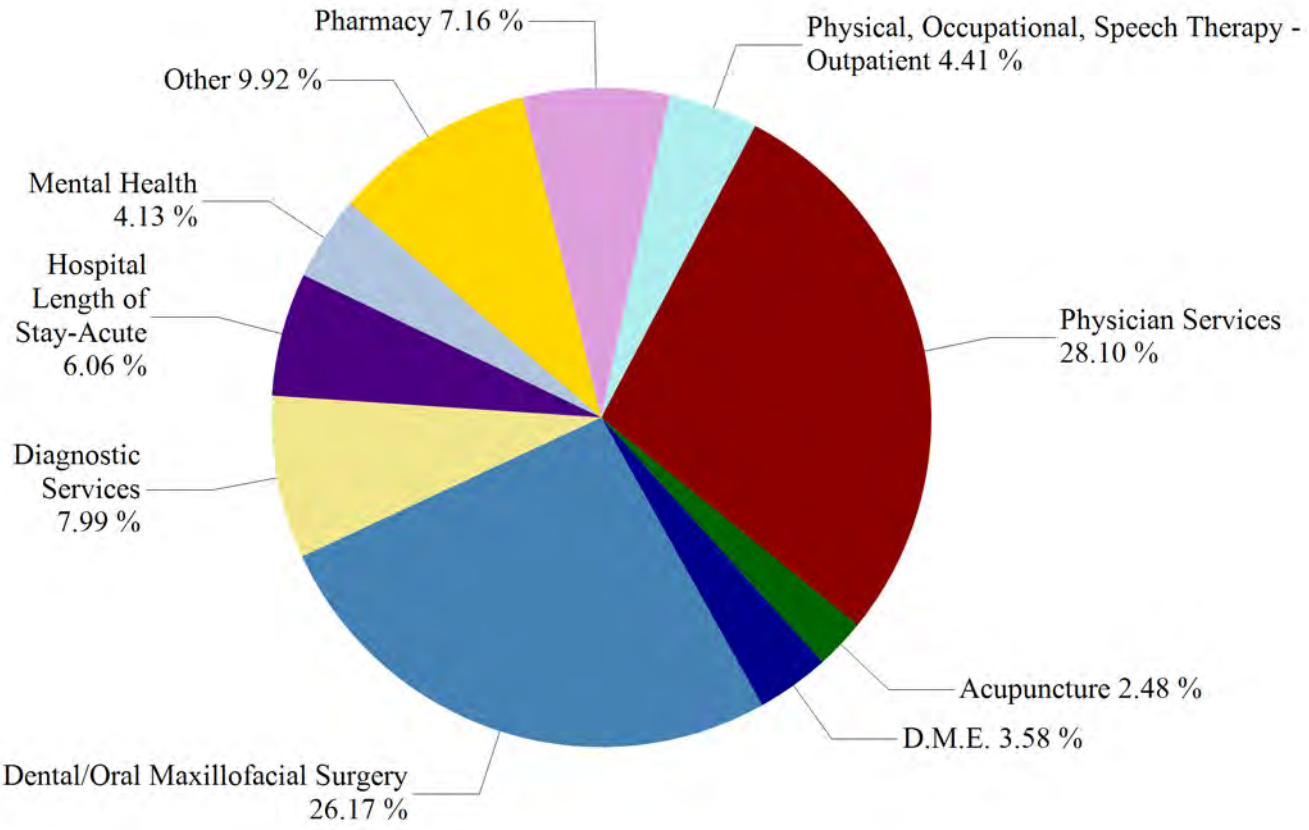
Outcomes by Who Filed the Case

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 2011.



HEAU Mediated Appeals and Grievances Cases
Types of Services Denied

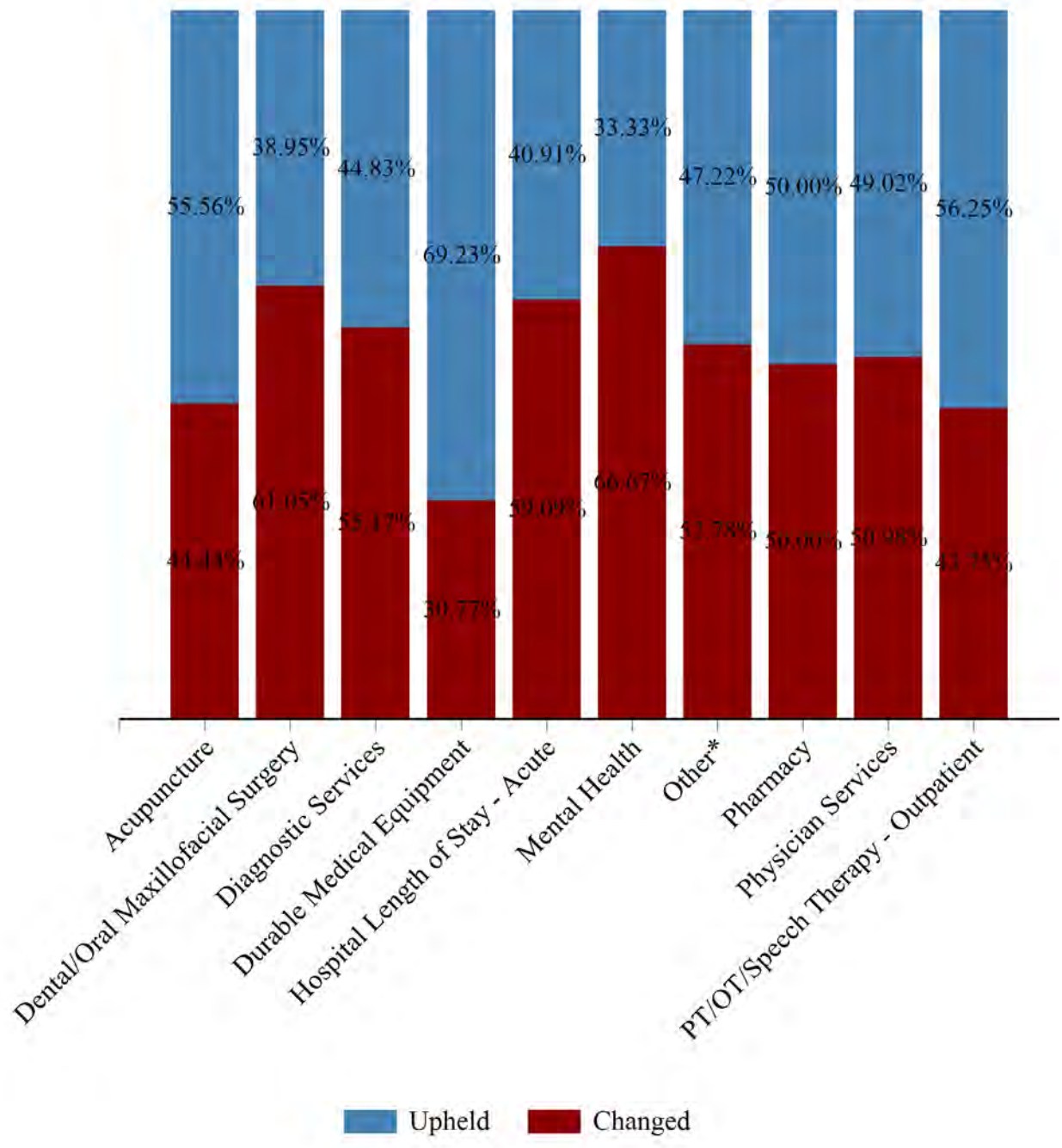
The chart below identifies the types of services involved in the appeals and grievances cases the HEAU mediated and closed during FY 2011.



* "Other" includes emergency room, habilitative services, optometry, podiatry, 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 2011 based on the type of services denied.



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