The

Maryland Insurance

Administration's 2001

Report

On

The Health Care Appeals &

Grievance Law

November 2002

Steven B. Larsen
Commissioner

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

The Appeals & Grievance Law passed by the General Assembly in 1998 established a procedure for consumers to appeal decisions made by health maintenance organizations (HMO's), insurers and nonprofit health service plans (also referred to as "Carriers" or "health plans") that a covered health service is not medically necessary. (Appendix A). The law took effect January 1, 1999, and was codified at § 15-10A *et seq.* of the Insurance Article. One key component of the legislation is a consumer's right to internal and external review where care is denied on the grounds that it is not "medically necessary." This law also gave the Administration regulatory authority over private review agents and established a new statutory process to certify medical directors of HMOs. Regulatory oversight of private review agents and medical directors is codified as Title 15, Subtitle 10B and Subtitle 10C, respectively.

The Appeals & Grievance Law was revised in 2000 to: 1) clarify that Carriers must send written notice of the adverse decision to the member and the member's healthcare provider within five days; 2) require that the written notice inform the member that the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General ("HEAU") is available to assist the member; 3) establish the authority of the Commissioner to conduct market conduct examinations of private review agents; and 4) clarify the private review agent law so that the Commissioner could implement the private review agent statute in accordance with the provisions established by the enactment of Chapter 112, Acts of 1998.

In 2001 the law was amended to: 1) require Carriers to allow members or healthcare providers acting on behalf of members to file a grievance 180 days after the member receives the adverse decision for a retrospective denial; 2) allow a member or provider on behalf of a member 30 working days after the receipt of a grievance decision to file a complaint with the Commissioner to review the grievance decision; and 3) require all Carriers to report the number of adverse decisions issued by the Carriers to the Commissioner on a form required by the Commissioner. In addition, the law was amended to provide that §§15-10B and 10D of the Insurance Article apply to health maintenance organizations (HMO'S), and that under certain circumstances a private review agent's grievance decision must be based upon the professional judgment of a board certified or eligible health care service reviewer.

This report summarizes the data reported to the Administration by the Carriers for calendar year 2001 as required by § 15-10A-06 of the Insurance Article. This report also summarizes complaint information and the enforcement activity of the Insurance Administration for calendar year 2001. Reports have been previously submitted for Calendar Year 1999 and 2000.

Pursuant to § 15-10A-08 of the Insurance Article, the HEAU is also required to submit a report in November of each year. The HEAU report is based on a fiscal year and as such, the data contained in the Administration's report and HEAU's report do not measure activity for comparable periods of time.

II. MARYLAND'S APPEALS & GRIEVANCE LAW

The process is divided into two parts: a) the internal review which is conducted by the Carrier; and b) the external review which is conducted by the Insurance Administration and occurs if the member is dissatisfied with the Carrier's decision at the internal level and files a complaint with the Administration.

A. Internal Review: The Carrier's Internal Grievance Process

The Appeals & Grievance Law requires that if the Carrier denies services based on lack of medical necessity, the Carrier must provide the member a written "adverse decision" within five (5) working days of the decision.

The written adverse decision must:

- State in clear and understandable language the specific factual basis for the decision.
- Reference the specific criteria relied on to make the decision.
- State the name, address and phone number of the person responsible for the decision.
- Explain in detail the Carrier's internal grievance process.
- Inform the member that the HEAU can assist him.
- Provide the address and telephone number, facsimile number and e-mail address of the HEAU.
- Inform the member that they have a right to file a complaint with the Commissioner within 30 working days after receipt of a Carrier's grievance decision if the member is dissatisfied with the outcome.
- Inform the member that a complaint may be filed without first filing a grievance with the Carrier if there is a compelling reason.
- Provide the Commissioner's address, telephone number and facsimile number.

If the member, or a provider acting on behalf of the member, wishes to challenge the adverse decision of the Carrier, the member must go through an internal process which is established by the Carrier. However, if the case involves a compelling reason, the complaint may be filed directly with the Administration.

This internal grievance process must provide:

- An expedited procedure for use in an emergency case for purposes of rendering a grievance decision within 24 hours of the date a grievance is filed with the Carrier.
- That a Carrier render a final decision in writing on a grievance within 30 working days after the date the grievance is filed. If the grievance involves a retrospective denial, the Carrier has 45 working days to render a decision.

The grievance decision shall:

- State in clear language the specific factual bases for the decision.
- Reference the specific criteria relied on to make the decision.
- State the name, business address and business telephone number of the person making the decision.
- Inform the member that he has a right to file a complaint with the Commissioner within 30 working days after receipt of a Carrier's decision if the member is dissatisfied with the decision.
- Provide the Commissioner's address, telephone number and facsimile number.

Consumers may receive assistance through the internal grievance process from the HEAU. The HEAU will attempt to mediate disputes between the member and the Carrier or, in the appropriate case, help the member file a grievance.

B. External Review: Appeals & Grievance Complaint Process at the Insurance Administration.

If the complainant is dissatisfied with the grievance decision, the complainant may file a written complaint with the Insurance Administration. The Administration will conduct an investigation by examining all relevant information including the patient's medical records and information from the Carrier.

Once the Carrier's response and all relevant information is received, the case is reviewed to determine if it needs to be referred to an Independent Review Organization (IRO) for medical review. A matter may not be referred to external review for several reasons, including the absence of jurisdiction by the Administration, or because the Carrier has decided to provide the services in question. It may be determined that a complaint is not within the jurisdiction of the Administration either because of ERISA, which preempts the State in cases involving self-insured health plans, or because the complaint involves the Medicare or Medicaid programs, etc. (Appendix C1, C2). If so, the complainant is notified of this determination by mail, and the complaint is transferred to the appropriate agency. Complaints that relate to quality of care are referred to the Department of Health & Mental Hygiene ("DHMH") for review. (Appendix C3). If a complaint has a medical necessity component and a quality of care component, then both the DHMH and the Administration will investigate the portions of the case over which these respective agencies have jurisdiction.

If the Administration determines it has jurisdiction and the complaint involves a denial based on the lack of medical necessity (as opposed to denials based on specific contractual exclusions), the case will be referred to the IRO. When complaints are

referred to an IRO, the IRO is requested to examine the utilization review criteria applied in the case, as well as the specific judgment of the Medical Director made under the utilization review criteria. If the IRO's recommendation is to overturn the Carrier's denial, an Order is issued against the Carrier. The Order is forwarded to the Carrier and accompanied by a notice that the Carrier has the right to request a hearing. At the same time, the complainant is notified of the outcome. Orders may also be issued as a result of failure to comply with the procedural requirements of the law, i.e., failure to issue a written notice of adverse or grievance decision.

If the IRO's recommendation is to uphold the Carrier's denial, the complainant is notified by mail and informed that he or she has the right to request a hearing. The Carrier is also informed of this decision.

Complainants may withdraw their complaints during the investigation. Also, some complaints are closed because the complainant fails to respond to a request for information. This only occurs after at least one written warning is issued to the complainant stating that the file will be closed unless additional information is provided. In addition, Carriers may reverse their original denials for a number of reasons, including following a review of information submitted during the appeals process. Maryland law allows health care providers to file complaints on behalf of the patients being treated.

III. ERISA PREEMPTION OF STATE MEDICAL NECESSITY REVIEW LAWS

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law regulating employee pension and benefit plans. ERISA establishes comprehensive minimum standards for pension plans and some standards for health benefit plans. ERISA affects state laws as follows:

1. ERISA preempts state laws that "relate to" employee health plans.

2. ERISA "saves" from preemption state laws that regulate insurance.

3. However, even state laws that are "saved" from preemption because they regulate insurance can be preempted if they conflict with a substantive portion of ERISA.

Federal courts have differed in their interpretations of the extent of ERISA's preemption of state laws and conflicting decisions have been rendered. There have been two recent U.S. Court of Appeals decisions relating to whether external appeal statutes in Illinois and Texas are preempted by ERISA.

The U.S. Court of Appeals for the 5th Circuit found that the Texas external appeal statute is preempted, *Corporate Health Ins. Plans, et al. V. Texas Dept of Ins., 215 F.3d 526 (5th Cir. 2000),* while the U.S. Court of Appeals for the 7th Circuit subsequently

found that the Illinois appeal statute is not preempted, *Moran v. Rush Prudential HMO, Inc., 230 F.3d. 959 (7th Cir. 2000).*

A petition for a writ of certiorari for U.S. Supreme Court consideration was filed for both decisions. On June 29, 2001, the Court granted certiorari for the 7th Circuit case and argument was heard on January 16, 2002. The Supreme Court held that ERISA did not preempt Illinois's independent review

The Court first decided, based on a "common sense" approach, that HMO's are insurers for the purpose of ERISA. ERISA saves laws regulating insurance from preemption. Federal courts in Texas had previously decided that HMO's are not insurers, and therefore laws regulating HMO's are not saved from preemption. The Supreme Court rejected that analysis in this decision. Although HMO's provide health care services, they also spread risk among their members, making them subject to regulation as insurers. HMO's fall within ERISA's savings clause.

The Court then considered whether the law was preempted because it provided an alternative enforcement mechanism in conflict with ERISA. The Court determined that there was no impermissible conflict. The Illinois law did not create a new cause of action. The insured's available ultimate relief remained a suit for benefits in federal court under ERISA. The Court rejected the argument that state independent review laws interfered with Congress's goal of uniformity. The Court pointed out that in enacting the savings clause, Congress understood that state insurance laws were not uniform.

The Court of Appeals of Maryland has also determined that Maryland's Appeals and Grievance law is not preempted by ERISA. The case arose from two complaints filed with the Administration regarding denials of benefits based on medical necessity. The Administration's investigations in both cases found that the treatment was medically necessary as well as other violations related to the review for medical necessity and the timeliness and content of the notices of the denials.

After analysis of the Supreme Court's decision in *Rush Prudential*, the Court of Appeals held that Subtitles 10A and 10B of Title 15 of the Insurance Article regulate insurance and do not directly conflict with the provisions of ERISA or the associated federal regulations, and are not preempted by ERISA. Maryland's Unfair Claim Settlement Practices Act authorizes the Commissioner to order payment for previously denied benefits only if the claim is within the terms of the insurance contract. This falls within the *Rush Prudential* standard that the state statute may not enlarge the claim beyond the benefits available in an action under ERISA. The Commissioner's orders were found to be valid in their entirety.

IV. CERTIFICATION AND OVERSIGHT OF MEDICAL DIRECTORS OF HEALTH MAINTENANCE ORGANIZATIONS AND PRIVATE REVIEW AGENTS

Every health maintenance organization licensed to do business in Maryland is required to certify its medical directors. Each medical director appointed by a health maintenance organization must submit an application for certification to the Commissioner for consideration and approval. The Commissioner must certify all medical directors before they are hired to act as medical directors for a health maintenance organization. Medical directors are primarily responsible for utilization review decisions and the establishment and maintenance of quality assurance and utilization management policies and procedures for the health maintenance organization. Certification by the Commissioner ensures that all medical directors meet particular qualifications to perform their duties.

Any entity or person performing utilization review on behalf of a Maryland business entity, or a third party that pays for, provides or administers health care services to citizens of this State is required to submit an application to the Commissioner for approval by the Commissioner prior to conducting utilization review in this State. This entity or person is called a private review agent.

The Medical Director/Private Review Agent Oversight Unit (MD/PRA Oversight Unit) reviews applications for certification of private review agents to determine whether the utilization review policies, procedures and criteria of private review agents are compliant with Maryland law and regulations. The MD/PRA Oversight Unit is also responsible for ensuring that medical directors of health maintenance organizations licensed to do business in Maryland meet the requirements for certification. In 2001, there were 33 certified medical directors working for HMOs in Maryland and 106 certified private review agents. As of November 15, 2002, there are 70 certified medical directors working for HMOs in Maryland and 98 private review agents.

Uniform Treatment Plan Form Compliance*:*

The Uniform Treatment Plan Form ("UTPF") is a form used by private review agents to authorize outpatient treatment for behavioral health care services. The regulations for the UTPF became effective August 21, 2000, and applied to all requests for treatment on or after October 1, 2000. The MD/PRA Oversight Unit monitored compliance efforts of entities required to use the UTPF and addressed approximately 50 complaints and inquiries from health care providers regarding the UTPF.

V. SUMMARY OF CARRIER DATA ON GRIEVANCES REPORTED TO THE ADMINISTRATION BY CARRIER

Section 15-10A-06 of the Insurance Article requires Carriers to submit quarterly reports which provide:

- The outcome of each grievance filed with the Carrier;
- The number and outcomes of cases that were considered emergency cases under §15-10A-02(b)(2)(i) of Subtitle 10A;

- The time within which the Carrier made a grievance decision on each emergency case;
- The time within which the Carrier made a grievance decision on all other cases that were not considered emergency cases; and
- The number of grievances filed with the Carrier that resulted from an adverse decision involving length of stay for inpatient hospitalization as related to the medical procedure involved; and
- The number and outcome of all other cases that resulted from an adverse decision involving the length of stay for inpatient hospitalization as related to the medical procedure involved.

Based on the information provided by the Carriers, in 2001 the largest volume of grievances involved denials of inpatient hospital days. (Appendix B1, B2, B3). In 1999 and 2000, the largest volume of grievances were also concerning inpatient hospital days. (Appendix B2). Similar to the prior two years, physician services, emergency room services and mental health services were among the top reasons for grievances in 2001. However, the category which includes podiatry, dental, optometry and chiropractic services, which in prior years had been ranked number ten, in 2001 it was the third largest reason for grievances.

The Carriers also report the number of internal decisions where they overturn themselves. (Appendix B4). The data reveals that in 1999 the majority of the reversals occurred for pharmacy services. (Appendix B5). In year 2000, the majority of the reversals involved lab services, home health services, emergency room services, and pharmacy services. (Appendix B6). In 2001, the largest number of reversals were for laboratory and radiological services (Appendix B7). The Carriers also reported that in 2001 the fewest reversals occurred where mental health services were at issue. This was also the case in 1999 and 2000.

VI. SUMMARY OF STATISTICAL DATA BASED ON COMPLAINTS FILED WITH THE ADMINISTRATION

A. Number Of Complaints Filed

The Appeals & Grievance Unit received a total of 1312 complaints asserting a denial of care of coverage based on the lack of medical necessity. (Appendix C1). This is down from the 1526 received in 2000, but more than was received in 1999 (1,063). As a point of comparison, in 2001 the Administration received approximately 8,000 complaints in its Life & Health Unit involving non-medical necessity disputes. These complaints include disputes over whether a benefit is covered under a contract, the amount of reimbursement, as well as payments under life or disability insurance policies. Complaints may be filed by providers on behalf of complainants. This includes individual doctors as well as facilities, such as hospitals.

B. Jurisdictional Issues

As indicated above, the Unit received a total of 1312 complaints that dealt with or alleged medical necessity denials. The initial investigation of these cases revealed that the Administration did not have jurisdiction in 469 cases. (Appendix C2). In 246 cases, ERISA preempted the State's jurisdiction. ERISA's preemption applies to employer sponsored benefit plans, where the health benefits are self-insured. (See Section III for discussion on ERISA preemption.) If it is determined that the complaint is one which falls outside of the regulatory authority of the Administration, the complainant is referred to the appropriate Agency which has jurisdiction to review their complaint. In the case of ERISA, the 246 complaints were referred to the Department of Labor.

During Calendar year 2001, the Administration also referred:

- 60 cases to OPM (Federal Employees)
- 27 cases to Medicaid
- 28 cases to Medicare
- 81 cases to Insurance Department in Another State
- 27 cases to other state agencies including DHMH and the Workers Compensation Commission

Also, in 254 cases, the complainants had not exhausted their internal grievances and thus the complaint was referred to the HEAU. (Appendix C1). Complainants chose to withdraw their complaints in 30 cases, and 99 cases were closed because the complainants failed to provide information that was necessary to complete the investigation. An example of this occurs where signed consent forms were not provided to the Administration, enabling the Administration to obtain medical records, or where the provider or patient failed to provide medical records which are essential for the review. No action was required in 68 cases.

C. Synopsis Of Complaints Investigated By The Administration

In 254 complaints which were filed with the Administration, the internal grievance process had not been exhausted. Therefore, the complainants were forwarded to the HEAU for assistance. The outcome of the remaining 392 complaints was as follows:

CARRIER REVERSED ITSELF DURING INVESTIGATION	165
CARRIER UPHELD BY MIA	168
CARRIER REVERSED BY MIA	50
CARRIER MODIFIED BY MIA	7
COMPLIANCE ORDER	2

The Carrier reversals occurred for several reasons including receipt of more information by the Carrier or an administrative decision to provide care. As indicated in

Appendix C5 and C6, the majority of the complaints investigated by the Administration fell into three categories: Physician Services, Hospital Denials and pharmacy services.

VII. CONSUMER SURVEY

Surveys were sent to 235 individuals who had filed complaints with the Unit; the Administration received 133 responses. The surveys revealed that, overall, consumers were satisfied with the assistance they received from the HEAU and the Administration, although most did not feel that the Carrier's internal process was fair. (See Appendix D). The consumers who responded indicated that they would use the process again if the need arose.

A sample of some of the comments are as follows:

- Very satisfied with MIA; not satisfied with company initially.

- Although the final results were negative, [the investigator] kept me informed at every turn and very understanding and compassionate.

- The investigator's knowledge and dedication to our case was of the highest level. What an outstanding worker, in an outstanding department.

- Kept getting bills, I routed them to the insurance co. They ignored them. I asked if they weren't going to pay them, at least tell me why. I then sent you and them a letter stating what I was doing (asking MIA to investigate). Everything came up roses after that. Thanks bunches [initialed/signed]

- Exceptional service and attention – the best I've ever received from a government agency.

- I am satisfied that my patient's case for insurance coverage was affirmed on review. This would not have occurred without MIA intervention. I remain frustrated with the intrusion of the insurance company into patient care. This was, unfortunately, not resolved.

- The Investigator was very professional and very thorough in handling and explaining the procedures. The insurance carrier showed callous disregard for the documents submitted to the grievance procedure. I consider myself fortunate to have been insured under Maryland law because I believe that in most states the high-handed and self-serving tactics of the carrier would have prevailed.

- This office provides an invaluable service to the public, protecting them from abuses and excesses perpetrated by the insurance industry. My appeal to the insurance company received a summary rejection prior to appealing to the MIA. Thank you again for offering this opportunity to appeal matters beyond the insurance company's internal process.

- I am so grateful that Maryland has this wonderful commission to assist taxpayers when they need assistance in dealing with insurance companies.

- The MIA and HAU were very kind and helpful but the bottom line is that the insurance company still took advantage of a very ill woman. How often do they get away with this when the patient has nobody to advocate for them?

VIII. ENFORCEMENT ACTIVITIES

The statutory authority for the Commissioner to enforce the Appeals & Grievance law is found in §15-10A et al; §15-10B et al; §4-113; and §27-303 of the Insurance Article and § 19-729 and § 19-730 of the Health General Article. These provisions allow the Commissioner to require the payment of medically necessary treatment. The Commissioner also has authority to fine a carrier for sending an adverse or grievance decision letter which did not comply with the law; failure to timely authorize medically necessary services; and failure to have the appropriate physician conduct the utilization review.

A. Appeals & Grievance Complaint Unit

The Administration issued 52 Orders based on the complaints which it received. These Orders were issued based on the Carrier's inappropriate denial of medically necessary services; the Carrier's failure to send statutory complaint notices when services are denied as not medically necessary; and the Carriers' failure to timely authorize services. The services that are the subject of these Orders include mental health treatment, pharmacy services, and durable medical equipment. In addition, the Administration also entered into 5 Consent Agreements in cases. Administrative Penalties of $45,500 have been collected.

A summary of the Orders and Consent Orders issued follows:

ORDERS

MIA vs. CareFirst of Maryland, Inc. – Case No.: 98-3/01

The Administration determined that CareFirst violated § 15-10A-04(c) by failing to authorize medically necessary partial hospitalization from February 5, 2000 through February 9, 2000. The Administration ordered CareFirst to immediately authorize payment for partial hospitalization from February 5, 2000 through February 9, 2000.

MIA v. Capital Care, Inc. – Case No.: 117-3/01

The Administration determined that it was medically necessary for the patient to be admitted to an inpatient rehabilitation treatment facility. Capital Care's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article.

MIA v. Cigna Healthcare of the Mid-Atlantic, Inc. – Case No.: 121-3/01

The Administration determined that the proposed liposuction surgery was medically necessary. CIGNA's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered CIGNA to immediately authorize and pay for the surgery.

MIA v. Optimum Choice, Inc. – Case No.: 126-3/01

The Administration determined that it was medically necessary for the patient to receive the medical food for the treatment of Rett Syndrome. OCI's failure to authorize Pediasure for the patient violated § 15-10A-04 of the Insurance Article. The Administration ordered OCI to immediately authorize payment for Pediasure for the patient.

MIA v. Capital Care, Inc. – Case No.: 148-3/01

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at Rosehill Treatment Center. The Administration ordered Capital Care to immediately authorize payment for the dates of service from December 1, 2000 through February 26, 2001, and continuing as along as medically necessary under the terms of the health benefit plan. Capital Care also failed in its adverse decision and grievance letters to include that the member has a right to file a complaint with the Commissioner within 30 days after receipt of the carrier's grievance decision. The Administration ordered Capital Care to pay an administrative penalty of $2,500 for violating § 15-10A-02(i)(1)(4) of the Insurance Article.

MIA v. Optimum Choice, Inc. – Case No.: 149-3/01

The Administration determined that it was medically necessary for the patient to have a bilateral reduction mammoplasty. OCI's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered OCI to immediately authorize payment for the breast reduction, pursuant to

§ 15-10A-04(c)(i)(2) of the Insurance Article.

MIA vs. PHN-HMO, Inc.- Case No.:170-4/01

The Administration determined that acute inpatient hospitalization from March 1, 2001 through April 12, 2001 was medically necessary. PHN's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered PHN to immediately authorize payment for inpatient acute care for March 16, 2001 through April 12, 2001, and on April 12, 2001, PHN was required to promptly review requests for all health care services, pursuant to § 15-10A-04(c)(2)(i)(2), and determine if additional services continued to be medically necessary.

MIA v. PHN-HMO, Inc. – Case No.: 184-4/01

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Watershed from December 23, 2000 through December 27, 2000. PHN's failure to pay benefits for the medically necessary services in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c). The Administration ordered to immediately PHN authorize payment to The Watershed from December 23, 2000 through December 27, 2000, pursuant to § 15-10A-04(c) of the Insurance Article. Also, PHN's failure in its December 27, 2000 adverse decision letter to include that the member has a right to file a complaint, violated § 15-10A-02(f) of the Insurance Article. In addition, PHN's failure to include information concerning the Health Education and Advocacy Unit, as well as information concerning filing a complaint for a compelling reason, also violated § 15-10A-02(f) of the Insurance Article. The Administration ordered PHN to pay an administrative penalty of $2,500 for violation of § 15-10A-02(f) of the Insurance Article.

MIA v. PHN-HMO, Inc. – Case No.: 187-4/01

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Watershed from October 13, 2000 through October 27, 2000. PHN's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered PHN to immediately authorize payment to The Watershed for dates of service from October 13, 2000 through October 27, 2000, pursuant to § 15-10A-04(c) of the Insurance Article. Also, PHN's failure in its October 18, 2000 adverse decision letter to include that the member had a right to file a complaint with the Commissioner within 30 days after receipt of the Carrier's grievance decision, violated § 15-10A-02(f) of the Insurance Article. In addition, PHN failed to include information concerning the Health Education and Advocacy Unit, as well as information concerning filing a complaint for a compelling reason, which are also violations of § 15-10A-02(f) of the Insurance Article. The Administration ordered PHN to pay an administrative penalty of $2,500 for violation of § 15-10A-02(f) of the Insurance Article.

MIA v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. - Case No.: 188-4/01

The Administration determined that it was medically necessary for the patient to receive skilled nursing services from February 2, 2001 through March 1, 2001, in accordance with § 15-10A-04(c) of the Insurance Article. Kaiser's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Kaiser to immediately authorize payment for the skilled nursing services received beyond February 2, 2001 to March 1, 2001. The Insurance Administration determined that Kaiser failed to include in the February 2, 2001 notice: a) a statement that the Health Advocacy Unit was available to assist the member in both mediating and filing a grievance under the carrier's internal appeals process; b) the specific criteria relied upon; and c) information concerning the member's right to file a complaint with the Commissioner prior to exhaustion of the internal process, for a compelling reason. This constituted a violation of § 15-10A-02(f) of the Insurance Article. The Administration ordered Kaiser to pay an administrative penalty of $2,500 for violation of § 15-10A-02(f) of the Insurance Article.

MIA v. MAMSI Life and Health Insurance Company – Case No.: 205-4/01

The Final Order issued by the Commissioner determined that at the hearing MAMSI had met its burden to demonstrate that the service did not meet the definition of medical necessity in its member's policy. The Commissioner found that MAMSI had not violated §15-10A-04(I). However, the Commissioner also found that MAMSI had not issued a timely written notice of its grievance decision, and was in violation of §15-10A-02(b)(2)(ii). The Commissioner ordered MAMSI to pay an administrative penalty of $2,500.00

MIA v. United Concordia Dental Plans, Inc.- Case No.: 212-4/01

The Administration determined that it was medically necessary for the patient to have the crown and crown build-ups. The Administration determined that United Concordia violated Section 15-10A-04(c) of the Insurance Article by failing to authorize payment for the medically necessary crown and crown build-ups. The Administration ordered United Concordia to immediately issue payment for the medically necessary crown and build-ups of crowns, pursuant to § 15-10A-04(c) of the Insurance Article. In addition, the Administration determined that United Concordia violated Section 15-10A-02(i) by failing to send the members details of its internal grievance process and information concerning the Health Advocacy Unit. The Administration ordered United Concordia to pay an administrative penalty of $2,500 for violation of § 15-10A-02(i) for failing to send the notice required concerning the Health Education and Advocacy Unit and for failing to inform the consumer of his right to file a complaint with the Commissioner.

MIA v. CareFirst of Maryland, Inc. – Case No.: 218-4/01

The Administration determined that CareFirst violated § 15-10A-04(c) by failing to authorize the medically necessary inpatient admission of March 20, 2001 through April 20, 2001. The Administration ordered CareFirst to immediately authorize payment

for the inpatient hospitalization from March 20, 2001 through April 20, 2001 and immediately conduct a review of the patient's current medical status to determine if inpatient hospitalization continued to be medically necessary.

The Carrier requested a hearing. Following the hearing, a Final Order was issued upholding the Administration's determination.

MIA v. MD-Individual Practice Association, Inc. – Case No.: 227-5/01

The Administration determined that it was medically necessary for the patient to receive the ABI Vest® Airway Clearance System. MD-IPA's failure to authorize and pay benefits for this medically necessary item in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered MD-IPA to pay for the ABI Vest® Airway Clearance System, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. CareFirst of Maryland, Inc. – Case No.: 229-5/01

The Administration determined that partial hospitalization, from March 7, 2001 through March 27, 2001, was medically necessary. The Administration ordered CareFirst to immediately authorize payment for partial hospitalization beginning March 7, 2001 with discharge on March 27, 2001, pursuant to § 15-10A-04(c)(2) of the Insurance Article.

MIA v. Freestate Health Plan, Inc. – Case No.: 247-5/01

The Insurance Administration determined that the procedure was not investigational/experimental. Freestate's failure to pay benefits for this service in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c). The Administration ordered Freestate to immediately authorize payment for the Intradiscal Electrothermal Therapy, pursuant to § 15-10A-04(c).

The Carrier requested a hearing. A decision is pending.

MIA v. Optimum Choice, Inc. – Case No.: 253-5/01

The Administration determined that it was medically necessary for the patient to have dermabrasion of the nasal tip. OCI's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law constitutes a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered OCI to immediately authorize payment for the dermabrasion of the nasal tip, pursuant to § 15-10A-04 of the Insurance Article.

MIA v. PHN-HMO, Inc. – Case No.: 272-5/01

The Administration determined that acute inpatient hospitalization from March 2, 2000 through March 9, 2000 was medically necessary. PHN's failure to pay benefits for the medically necessary services in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered PHN to immediately authorize payment for inpatient acute care for March 2, 2000 through March 9, 2000, pursuant to § 15-10A-04(c)(2) of the Insurance Article.

MIA v. Aetna U.S. Healthcare, Inc. – Case No.: 283-5/01

The Administration determined that it was medically necessary for the patient to have gastric bypass surgery. Aetna's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Aetna to immediately authorize payment for the gastric bypass surgery.

MIA v. Aetna U.S. Healthcare, Inc. – Case No.: 284-5/01

The Administration determined that it was medically necessary for the patient to be hospitalized from November 14, 2000 through November 16, 2000. Aetna's failure to pay benefits for the medically necessary services in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Aetna to immediately authorize payment for the dates of service from November 14, 2000 through November 16, 2000, pursuant to § 15-10A-04(c) of the Insurance Article. The Administration also ordered that Aetna pay a total administrative penalty of $5,000 ($2,500 for each violation) for violation of § 15-10A-02(i)(1)(ii)(4) of the Insurance Article for its noncompliant letters of November 17, 2000 and March 12, 2001.

MIA v. Optimum Choice, Inc. – Case No.: 288-5/01

The Administration determined the septorhinoplasty was medically necessary. OCI's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered OCI to immediately authorize payment for the septorhinoplasty, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. Aetna U.S. Healthcare, Inc. – Case No.: 311-6/01

The Administration determined that it was medically necessary for the patient to have bilateral breast reduction mammoplasty. Aetna's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Aetna to authorize payment for bilateral breast reduction mammoplasty. The Administration determined that Aetna failed to use a Board Certified or eligible physician in the same specialty as treatment under review. The Administration ordered Aetna to pay an administrative penalty of $2,500 for violation of § 15-10B-07(a) of the Insurance Article.

MIA v. MD-Individual Practice Association, Inc. – Case No.: 330-6/01

The Administration determined that inpatient hospitalization from October 19, 2000 through October 24, 2000 was medically necessary. MD-IPA's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered that MD-IPA authorize payment for inpatient hospital days from October 19, 2000 through October 24, 2000.

MIA v. Capital Care, Inc. – Case No.: 362-7/01

The Administration determined that it was medically necessary for the off-label use of the prescription drug Provigil for the treatment of the patient's depression and chronic fatigue syndrome. Capital Care's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Capital Care to immediately authorize payment for the off-label use of the prescription drug Provigil, pursuant to § 15-10A-04 of the Insurance Article.

MIA v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. –Case No.: 411-7/01

The Administration determined that it was medically necessary to use the prescription drug Penlac. Kaiser's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04 of the Insurance Article. The Administration ordered Kaiser to authorize payment for the use of prescription drug Penlac, pursuant to § 15-10A-04 of the Insurance Article.

MIA v. CareFirst of Maryland, Inc. – Case No: 418-8/01

The Administration determined that it was medically necessary for the patient to receive partial hospitalization from November 8, 2000 through November 23, 2000 and intensive outpatient services from November 24, 2000 through February 2, 2001. CareFirst's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered CareFirst to immediately authorize payment for partial hospitalization from November 8, 2000 through November 23, 2000 and intensive outpatient care from November 24, 2000 through February 2, 2001, pursuant to § 15-10A-04(c)(2) of the Insurance Article.

MIA v. Coventry Healthcare of Delaware, Inc. – Case No: 429-8/01

The Administration determined that it was medically necessary for the patient to be hospitalized from December 27, 2000 through December 29, 2000. The Administration ordered Coventry to immediately authorize payment for inpatient hospital days from December 27, 2000 through December 29, 2000, pursuant to § 15-10A-04(c) of the Insurance Article. The Insurance Administration determined that Coventry's decision letters failed to comply with the requirements of § 15-10A-02(f) of the Insurance Article. The Administration ordered Coventry to pay an administrative penalty of $2,500, for its noncompliant letters.

MIA v. Group Hospitalization and Medical Services, Inc. – Case No: 436-8/01

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Caron Foundation from January 25, 2001 through February 23, 2001. The Administration ordered GHMSI to immediately authorize payment for inpatient residential treatment under the terms of the health benefit plan, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. MD-Individual Practice Association, Inc. – Case No: 446-8/01

The Administration determined it medically necessary for the member to have gastric bypass surgery. The Administration ordered M.D.-IPA to immediately authorize payment for gastric bypass surgery, pursuant to § 15-10A-04 of the Insurance Article.

MIA v. Washington National Insurance – Case No: 447-8/01

The Administration determined that the acupuncture/pressure services were medically necessary and ordered the carrier to pay for the medically necessary services. The Insurance Administration determined that Washington National violated § 15-10A-02(f) by failing to send a compliant adverse decision notice; § 15-10A-02(i) of the Insurance Article by failing to send the member a grievance decision notice; §15-10B-07(a)(3)(i) of the Insurance Article by not having at least 1 physician on the review panel who is board certified or eligible in the same specialty as the treatment under review. The Administration ordered Washington National to pay an administrative penalty of $2,500 for violation of § 15-10A-02(f) of the Insurance Article; $2,500 for violation of § 15-10B-07(a)(3)(i) of the Insurance Article and $2,500 for violation of § 15-10A-02(i) of the Insurance Article.

MIA v. PHN-HMO, Inc. – Case No: 467-9/01

The Insurance Administration determined that PHN failed in its March 21, 2001 adverse decision via Remittance Advice to comply with the requirements of § 15-10A-02 of the Insurance Article. The Administration ordered PHN to pay an administrative penalty of $2,500 for violation of § 15-10A-02(f) of the Insurance Article.

MIA v. Connecticut General Life Insurance Company – Case No.: 477-9/01

The Administration determined that Connecticut General violated §15-10A-02(f) of the Insurance Article by failing to send an adverse decision notice which complied with § 15-10A-02. The Administration ordered Connecticut General to pay an administrative penalty of $2,500 for violating § 15-10A-02(f) of the Insurance Article.

The carrier requested a hearing. Following the hearing, a Final Order was issued upholding the Administration's determination.

MIA v. CareFirst of Maryland, Inc. – Case No.: 482-9/01

The Administration determined that inpatient hospitalization from February 6, 2001 to February 16, 2001 was medically necessary. The Administration ordered CareFirst to immediately authorize payment for inpatient hospitalization from February 6, 2001 to February 16, 2001, pursuant to § 15-10A-04(c)(2) of the Insurance Article.

MIA v. Fidelity Insurance Company – Case No.: 488-9/01

The Administration determined that Fidelity violated § 27-303(1) of the Insurance Article by requiring that the patient obtain a second opinion, not required by the terms of the policy coverage, before considering a request for authorization of benefits. The Administration ordered Fidelity to pay the contractual amount for the patient's mental health benefits for the eight treatment sessions provided from February 9, 2001 through July 30, 2001.

MIA v. CareFirst of Maryland, Inc. – Case No: 542-10/01

The Administration determined that a TENS Unit was not experimental/investigational for this patient. CareFirst's failure to pay benefits for the medically necessary TENS Unit in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered CareFirst to authorize payment for the TENS Unit, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. Fidelity Insurance Company – Case No: 543-10/01

The Administration determined that Fidelity's failure to pay benefits for the medically necessary services and authorize the follow-up visit on March 16, 2001, in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Fidelity to immediately authorize payment for the follow-up visit on March 16, 2001, pursuant to § 15-10A-04(c) of the Insurance Article. The Administration determined that Fidelity's EOB sent to the member and provider on May 20, 2001, and the grievance letter dated August 10, 2001, failed to comply with § 15-10A-02(f) and (i) of the Insurance Article. The Administration ordered Fidelity to pay an administrative penalty of $2,500 for violation of § 15-10A-02 of the Insurance Article, for the May 20, 2001 EOB letter, and $2,500 for the August 10, 2001 grievance decision letter.

MIA v. PHN-HMO, Inc. – Case No: 544-10/01

The Administration determined that PHN violated § 15-10A-04(c) of the Insurance Article by failing to authorize partial hospital rehabilitation from January 13, 2001 through February 2, 2001. The Administration ordered PHN to immediately authorize coverage for the medically necessary partial hospital rehabilitation, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. Optimum Choice, Inc. – Case No: - 552-10/01

The Administration determined that bilateral breast reduction was medically necessary. OCI's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c). The Administration ordered OCI to immediately authorize payment for the breast reduction, pursuant to § 15-10A-04(c)(2)(i)(2) of the Insurance Article.

MIA v. Aetna U.S. Healthcare, Inc. – Case No: 577-11/01

The Administration determined that inpatient hospitalization from May 18, 2001 to May 20, 2001 was medically necessary. Aetna's failure to pay benefits for the medically necessary inpatient hospital days in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Aetna to immediately authorize payment for inpatient hospitalization from May 18, 2001 through May 20, 2001.

MIA v. PHN-HMO, Inc. – Case No: 598-11/01

The Administration determined that residential inpatient services from July 13, 2001 through July 18, 2001 were medically necessary. The Administration ordered

PHN to immediately authorize payment for inpatient residential services for July 13, 2001 through July 18, 2001, pursuant to § 15-10A-04(c)(2) of the Insurance Article.

MIA v. MD-Individual Practice Association, Inc. – Case No. 604-11/01

The Administration determined that it was medically necessary for the member to have the requested surgery. MD-IPA 's failure to pay benefits for this medically necessary service for total laparoscopic hysterectomy with bilateral salpingo-oophorectomy and peritoneal stripping, in accordance with it contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered MD-IPA to immediately authorize payment for the medically necessary surgery.

MIA v. PHN-HMO – Case No.: 624-11/01

The Administration determined that inpatient substance abuse service from September 7, 2001 through September 10, 2001 was medically necessary. PHN's failure to pay benefits for the medically necessary services in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c)(2) of the Insurance Article. The Administration ordered PHN to immediately authorize payment for inpatient rehabilitation services for September 7, 2001 through September 10, 2001, pursuant to § 15-10A-04(c)(2) of the Insurance Article.

MIA v. Optimum Choice, Inc. – Case No.: 643-11/01

The Administration determined that inpatient hospitalization on July 12, 2001, with discharge to an extended care facility on July 13, 2001, was medically necessary for the patient. OCI's failure to pay benefits for this medically service in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered OCI to immediately authorize payment for the inpatient hospitalization on July 12, 2001, with discharge to an extended care facility on July 13, 2001, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. CareFirst of Maryland, Inc. – Case No.: 644-11/01

The Administration determined that inpatient substance abuse services from May 3, 2001 through May 6, 2001, were medically necessary. CareFirst's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered CareFirst to immediately authorize payment for inpatient level of care from May 3, 2001 through May 6, 2001, pursuant to § 15-10A-04(c)(2) of the Insurance Article.

MIA v. Cigna Healthcare of the Mid-Atlantic, Inc. – Case No.: 660-12/01

The Administration determined that inpatient hospitalization on August 2, 2001 and August 3, 2001, with discharge on August 4, 2001, was medically necessary for the patient. The Administration ordered CIGNA to immediately authorize payment for the inpatient hospitalization of August 2, 2001 through August 3, 2001, pursuant to § 15-10A-04(c) of the Insurance Article. The Administration determined that CIGNA's grievance decision letter dated October 4, 2001 did not comply with the requirements of § 15-10A-02(i) in that the letter failed to state the specific criteria and standards on

which the decision was based. CIGNA's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered CIGNA to pay an administrative penalty of $2,500, for failing to reference the specific criteria relied upon in the October 4, 2001 grievance decision letter, in violation of § 15-10A-02.

The carrier requested a hearing. A decision is pending.

MIA v. Optimum Choice, Inc. – Case No. 684-12/01

The Administration determined that Tinnitus Retraining Therapy was not experimental. The Administration also determined that the carrier violated § 15-123 of the Insurance Article by failing to provide a systematic, scientific process to follow for evaluating emerging medical and surgical treatment to ensure that subscribers have access to the latest appropriate treatments. OCI's failure to pay benefits for this medically necessary service in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered OCI to immediately authorize coverage for Tinnitus Retraining Therapy, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. CareFirst of Maryland, Inc. – Case No.: 12-1/02

The Insurance Administration determined that the inpatient hospital stay of June 13, 2001 to June 14, 2001 was medically necessary. CareFirst's failure to pay benefits for the medically necessary services in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered CareFirst to immediately authorize payment for the inpatient hospital stay of June 13, 2001 to June 14, 2001, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. PHN-HMO, Inc. – Case No.: 34-1/02

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at Marworth from August 14, 2001 through August 20, 2001. PHN's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered PHN to immediately authorize coverage for the medically necessary dates of service from August 14, 2001 through August 20, 2001, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. Freestate Health Plan – Case No.: 44-1/02

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Caron Foundation from September 2, 2001 through September 7, 2001, and intensive outpatient treatment from September 8, 2001 to September 30, 2001. Freestate's failure to pay benefits for these medically necessary services in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Freestate to immediately authorize coverage for the medically necessary inpatient residential treatment from September 2, 2001 through September 7, 2001 and intensive

outpatient treatment from September 8, 2001 to September 30, 2001, pursuant to § 15-10A-04(c) of the Insurance Article.

The Carrier has requested a hearing.

MIA v. Aetna U.S. Healthcare, Inc. – Case No.: 53-1/02

The Administration determined that it was medically necessary for the patient to receive inpatient residential treatment at The Watershed from June 9, 2001 through June 21, 2001, and partial hospitalization treatment from June 22, 2001 through June 30, 2001. Aetna's failure to pay benefits for these medically necessary services, in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered Aetna to immediately authorize payment to The Watershed for dates of service June 9, 2001 through June 30, 2001, pursuant to § 15-10A-04(c) of the Insurance Article.

MIA v. Dental Benefit Providers of Maryland, Inc. – Case No.: 54-1/02

The Administration determined that it was medically necessary for the patient to have periodontal scaling and root planing as described by her dentist in his claim for covered services. The Administration also determined that the carrier had violated §15-10A-04(c) of the Insurance Article by failing to authorize payment for the medically necessary periodontal scaling and root planing. The Administration ordered the Carrier to immediately authorize payment for the medically necessary periodontal scaling and root planing.

MIA v. Optimum Choice, Inc. – Case No.: 80-2/02

The Administration determined that it was medically necessary for the member to have construction of the Cecum Neovagina. OCI's failure to pay benefits for this medically necessary service for construction of the Cecum Neovagina in accordance with its contract and Maryland law, constituted a violation of § 15-10A-04(c) of the Insurance Article. The Administration ordered OCI to immediately authorize payment for construction of the Cecum Neovagina, pursuant to § 15-10A-04 of the Insurance Article. The Administration determined that OCI violated § 15-10B-09.1. (1) by failing to have a physician with a specialty in gynecology participate in the grievance decision. The Administration ordered OCI to pay an administrative penalty of $2,500, pursuant to § 15-10B-09.1 and immediately comply with § 15-10B-09 of the Insurance Article.

The Carrier has requested a hearing.

CONSENT ORDERS

MIA v. PHN-HMO, Inc. – Case No.: 120-3/01

The Administration and PHN entered into a Consent Order whereby PHN paid for all medically necessary services and paid an administrative penalty of $2,500 for failing to send an adverse decision notice in compliance with § 15-10A-02(f) of the Insurance Article.

MIA v. MAMSI Life and Health – Case No.: 226-5/01

The Administration and MAMSI entered into a Consent Order whereby MAMSI agreed to immediately authorize payment for Neocate for the patient.

MIA v. George Washington University Health Plan – Case No.: 289-5/01

The Administration and GWUHP entered into a Consent Order whereby GWUHP agreed to pay benefits for the medically necessary services. The Administration suspended the penalty of $5,000, for violation of § 15-10A-02, so that the maximum funds were available for the carrier to pay claims and other financial obligations.

MIA v. Group Hospitalization and Medical Services, Inc. – Case No. 457-8/01

The Administration and GHMSI entered into a Consent Order based on three individual complaints whereby GHMSI agreed to authorize payment for medically necessary inpatient partial hospital and outpatient services.

MIA v. PHN-HMO, Inc. – Case No. 603-11/01

The Administration and PHN entered into a Consent Order whereby PHN agreed to pay for Procrit for treatment of Hepatitis C. PHN also agreed to pay an administrative penalty of $3,000.

B. MD/PRA Oversight Unit

The Administration issued 7 Orders resulting from a Carrier's use of an unregistered private review agent or medical director. The summary of the violations and Orders are as follows:

MIA v. Guardian Life Insurance Company of America, Case No: 237-4/00 and Case No: 415-8/00

The Administration found that the Carrier failed to file an internal grievance process, and failed to issue compliant adverse and grievance decision notices. The Administration also found that the Carrier failed to use certified private review agents to conduct utilization review on its behalf. The Carrier requested a hearing, but subsequently entered into a consent agreement which resulted in the collection of an administrative penalty of $65,500.

MIA v. Dentistat, Inc., Case No: 214-4/01

The Administration found that Dentistat, Inc. ("Dentistat") violated §15-10B-11 of the Insurance Article by conducting utilization review without a certificate of registration. Dentistat, Inc. was ordered to cease utilization review activities in Maryland and pay an administrative penalty of $5,000. Dentistat, Inc. requested a hearing, but failed to appear for the hearing. A default order was subsequently issued. Dentistat, Inc. did not seek judicial review, and the penalty was paid.

Insurance Administration v. Ameritas Life Insurance Corp., Case No: 321-6/01

The Administration determined that Ameritas Life Insurance Corp. ("Ameritas") violated §15-10B-11 of the Insurance article by conducting utilization review without a certificate of registration. Ameritas was ordered to cease utilization review activities in Maryland and pay an administrative penalty of $5,000. The order was not contested, and Ameritas paid the fine.

Insurance Administration v. P&R Dental Strategies, Inc., Case No: 318-6/01

The Administration found that P&R Dental Strategies, Inc. violated §15-10B-03(a) and §15-10B-11(9) of the Insurance Article by conducting utilization review without a certificate. P&R Dental Strategies was ordered to cease utilization review activities in Maryland and pay an administrative penalty of $5,000. The order was not contested, and P&R Dental Strategies paid the penalty.

Insurance Administration v. MEC Health Care, Inc., Case No: 321-6/01

The Administration found that MEC Health Care, Inc. violated §15-10B-03(a) and §15-10B-11(9) of the Insurance Article by conducting utilization review without a certificate. MEC Health Care, Inc. requested a hearing, but subsequently entered into a consent agreement which resulted in an administrative penalty of $3,500.

Insurance Administration v. Medical Imaging Network, Inc., Case No: 354-7/01

The Administration found that the Medical Imaging Network, Inc. violated §15-10B-03(a) and §15-10B-11(9) of the Insurance Article by conducting utilization review without a certificate. Medical Imaging Network, Inc. was ordered to cease utilization review activities in Maryland and pay an administrative penalty. The Medical Imaging Network, Inc. requested a hearing, but subsequently entered into a consent agreement and paid in an administrative penalty of $3,000.

Insurance Administration v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Case No: 319-6/01

The Administration found that the Carrier violated §15-10C-02 of the Insurance Article and COMAR 31.10.20.04A by using uncertified medical directors to make utilization review decisions. The Carrier was ordered to pay an administrative penalty of $5,000. The order was rescinded after the Administration determined that the Carrier issued 400 adverse decisions using uncertified medical directors. The Carrier entered into a consent agreement and paid an administrative penalty of $50,000.

C. Life & Health Market Conduct Unit

The Life & Health Market Conduct Unit performed four target examinations during 2001 that focused on compliance with laws and regulations regarding adverse decisions. Three of those examinations are complete and are therefore public documents. One examination is still in process and therefore the information regarding that examination is confidential pursuant to Maryland statute.

The complete examinations are:

1. Connecticut General Life Insurance Company
2. United HealthCare of the Mid-Atlantic, Inc.
3. Magellan Behavioral Health

Each examination found various areas on non-compliance with various laws and regulations. A summary of the violations for each examination is as follows:

1. Connecticut General Life Insurance Company

This target examination reviewed the Carrier's procedures and practices regarding denials of health benefit claims or denials of preauthorization of health care services based on decisions of medical necessity.

The focus was to determine whether the company was complying with Subtitles 10A and 10B of Title 15 of the Insurance Article and COMAR 31.10.18, 31.10.21 and 31.15.08. The company was found to be in direct violation of MIA Order #1090-8/99 dated August 12, 1999. That Order required the Carrier to comply immediately with §§ 15-10A-02(i) and 15-10A-02(b)(2).

Specifically, the examination revealed that the company failed (1) to state in detail the factual bases for denial; 2) to provide specific criteria and standards on which the decisions were made; 3) to provide information on the provider's or member's right to file a complaint; 4) to include the appropriate information in 12 point type, and 5) to give the address of the Health Advocacy Unit. The carrier also was cited for the failure to render a timely determination in violation of §15-10B-08(a) of the Insurance Article. In addition, the carrier was cited for violation of COMAR 31.10.18.03B which requires that if an EOB includes an adverse decision, then a notice must be issued which complies with 31.10.18.04B. Also, the carrier was cited for inadequate documentation and violation of § 15-10B-06(e) concerning appropriate documentation of behavioral health treatment denials.

The Report found various other statutory and regulatory violations. The Carrier and the Administration entered into a Consent Order whereby the Carrier agreed to take corrective action and pay a $40,000 administrative penalty.

2. United HealthCare of the Mid-Atlantic, Inc.

This target examination reviewed the Carrier's practices and procedures to determine whether it was in compliance with Subtitle 10A, 10B and 10C of Title 15 of the Insurance Article as well as COMAR 31.10.18 and 31.10.21. The company was cited for: 1) failing to provide a complete explanation of the clinical criteria on which the decision was based; 2) failing to send adverse decision notices within five working days; 3) failing to send an adverse decision notice which included the name or telephone number of the medical director; 4) contracting with a private review agent that did not hold a valid private review agent certification; and 5) conducting utilization review without having a valid private review agent certificate.

The Carrier and the Administration entered into a Consent Order whereby the company paid an administrative penalty of $300,000 and agreed to take corrective action.

3. Magellan Behavioral Health

This target examination reviewed the company's practices and procedures to determine whether it was operating in compliance with subtitle 10B of Title 15 of the Insurance Article. The company was cited for 1) failing to provide notices which identified the business address and telephone number of the physician that rendered the adverse decision; 2) not giving details of the internal grievance process and procedures; 3) not sending notices within five days of rendering the adverse decision; and 4) not identifying the criteria on which the adverse decision was based. The company was also cited for taking more than 2 working days to render a decision as well as not making extended stay authorization decisions within one day of receipt of the necessary information.

The Administration and the company entered into a Consent Order whereby the company paid an administrative penalty of $150,000 and agreed to take corrective action.

4. CIGNA Dental

In addition to the four targeted examinations, during the course of a scheduled examination of CIGNA Dental, the Unit discovered that the Company was in violation of Subtitle 10B of the Insurance Article.

In order to conduct utilization review, the company is required to have a Private Review Agent Certification issued by the Commissioner effective January 1, 1999. Prior to January 1, 1999, the company was required to have a Private Review Certification issued by the Secretary of the Department of Health and Mental Hygiene in order to conduct utilization review. The examination found that in January, 2001, the Company applied to the Maryland Insurance Administration for certification as a Private Review Agent in order to conduct utilization review. However, the company conducted

utilization review of claims without a certificate in the years 1999 and 2000. The company was cited for operating as an unauthorized Private Review Agent in the State.

The Administration and the company entered into a Consent Agreement whereby the company paid an administrative penalty of $25,000.

D. Life & Health Rate and Form Filing Unit

The Life and Health section conducted a desk audit of all the received and filed grievance processes to determine if the processes had been updated to reflect changes in the law. Carriers that were determined to have processes that were no longer compliant were directed to file new processes. Revised process filings were received from all of the carriers.

IX. CONCLUSIONS

The MD/PRA Oversight Unit, Life & Health Market Conduct, Life & Health Rate & Form File Unit, and Appeals & Grievance Unit work collectively to ensure regulatory compliance and protection of Maryland citizens. This is accomplished by:

- Weekly joint meetings of the members of units to discuss the activity of regulated entities including private review agents, Carriers and medical directors who make utilization review determinations.
- Monitoring the implementation of utilization management policies and procedures via consumer complaint management and market conduct examinations.
- Effective and efficient oversight of regulated entities and handling consumer complaints.
- Consistent review of utilization management policies and procedures and review criteria that medical directors approve.

Although only three years of data has been collected, it is evident that this law has had a positive effect on the ability of consumers to promptly obtain appropriate medically necessary services.

APPENDICES

APPENDICES

HEALTH CARE COMPLAINTS UNDER STATE LAW

1. Medical Necessity

A. Individual receives an adverse decision from carrier concerning whether treatment is medically necessary.

B. Individual must exhaust carrier's internal grievance process unless emergency or compelling reason. If it is a compelling reason, file the complaint with Insurance

C. Health Advocacy Unit of the Attorney General's Office can help with the Grievance Process.
I. Gather information
II. Prepare Grievance
(410) 528-1840
www.oag.state.md.us

D. If your complaint is not appropriately resolved then you can proceed by filing a written complaint with the:
Maryland Insurance Administration
525 St. Paul Place
Baltimore, MD 21202
1-800-492-6116

I. Gather Information
II. Consult with medical experts
III. Render a Final Decision.

2. Contract Issues

A. Individual informed by carrier that services not covered by contract.

B. File a complaint in writing with the:
Maryland Insurance Administration
525 St. Paul Place
Baltimore, MD 21202
1-800-492-6116

C. Maryland Insurance Administration will conduct investigation and render a decision.

3. Quality of Care

A. Individual believes services or treatment received from physician improper.

B. File complaint with the:
Maryland Insurance Administration
525 St. Paul Place
Baltimore, MD 21202
1-800-492-6116

C. Complaint referred to the Department of Health & Mental Hygiene for investigation.

4. No Jurisdiction

A. Category of cases the Maryland Insurance Administration does not have jurisdiction over:

- ERISA
- Medicare
- Medicaid

B. These cases are referred to appropriate Agency for investigation.

APPEALS AND GRIEVANCES

CARRIER'S INTERNAL GRIEVANCE STATISTICS BY CATEGORY - 2001

NAIC #	COMPANY NAME	GRIEVANCES FILED		A. INPATIENT HOSPITAL SERVICES		B. EMERGENCY ROOM SERVICES		C. MENTAL HEALTH SERVICES	
		COMPANY TOTAL	% OF ALL COMPANIES	NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL
95590	Aetna USHC(DE)/NYLCare	164	3.7%	26	15.9%	5	3.0%	10	6.1%
90611	Allianz Life Ins Co of N. America	3	0.1%	0	0.0%	0	0.0%	0	0.0%
71773	American National Life Ins Co	1	0.0%	0	0.0%	0	0.0%	0	0.0%
60836	American Republic Ins Co	1	0.0%	0	0.0%	0	0.0%	0	0.0%
61301	Ameritas Life Ins Co	21	0.5%	0	0.0%	0	0.0%	0	0.0%
96202	Capital Care, Inc. (CareFirst BlueChoice, Inc.)	41	0.9%	17	41.5%	0	0.0%	16	39.0%
47058	CareFirst of Maryland, Inc.	708	16.2%	428	60.5%	13	1.8%	124	17.5%
80799	Celtic Life Ins Co	22	0.5%	0	0.0%	0	0.0%	1	4.5%
48119	CIGNA Dental Health of Maryland	1	0.0%	0	0.0%	0	0.0%	0	0.0%
95599	CIGNA Healthcare Mid-Atlantic, Inc	287	6.5%	110	38.3%	5	1.7%	7	2.4%
77828	Companion Life Insurance Co	29	0.7%	0	0.0%	0	0.0%	0	0.0%
62308	Connecticut General Life Insurance	436	9.9%	135	31.0%	1	0.2%	50	11.5%
93769	Conseco Medical Insurance Co	7	0.2%	1	14.3%	0	0.0%	0	0.0%
71404	Continental General Ins Co	1	0.0%	0	0.0%	0	0.0%	0	0.0%
96460	COVENTRY (Principal HC of DE, Inc)	59	1.3%	3	5.1%	10	16.9%	0	0.0%
95574	Delmarva Health Plan, Inc.	22	0.5%	2	9.1%	0	0.0%	1	4.5%
47040	Dental Benefit Providers of MD	159	3.6%	0	0.0%	0	0.0%	0	0.0%
73288	Employers Health Ins Co	1	0.0%	0	0.0%	0	0.0%	0	0.0%
43010	Fidelity Ins Co (MD Fidelity)	86	2.0%	5	5.8%	39	45.3%	7	8.1%
70408	Fortis Benefits Ins Co	2	0.0%	0	0.0%	0	0.0%	0	0.0%
95572	Freestate Health Plan, Inc.	333	7.6%	164	49.2%	25	7.5%	42	12.6%
95666	Geo Washington U Health Plan	7	0.2%	5	71.4%	0	0.0%	0	0.0%
68322	Great-West Life & Annuity Ins Co	1	0.0%	0	0.0%	0	0.0%	0	0.0%
53007	Group Hosp & MedServ	80	1.8%	27	33.8%	0	0.0%	16	20.0%
64246	Guardian Life Ins Co Of America	53	1.2%	10	18.9%	0	0.0%	0	0.0%
93440	Highmark(TransGeneral)	2	0.0%	0	0.0%	0	0.0%	0	0.0%
55522	Kaiser Fndtn Health Plan-Mid-Atl	186	4.2%	34	18.3%	14	7.5%	13	7.0%
60321	MAMSI Life & Health Ins Co	344	7.8%	181	52.6%	100	29.1%	3	0.9%
96310	MD-Individual Practive Assoc.	135	3.1%	100	74.1%	12	8.9%	1	0.7%
97055	Mega Life & Health Ins. Co.	9	0.2%	0	0.0%	2	22.2%	0	0.0%
53031	Mid-Atlantic Vision Serv. Plan, Inc.	1	0.0%	0	0.0%	0	0.0%	0	0.0%
71412	Mutual of Omaha Ins Co	3	0.1%	3	100.0%	0	0.0%	0	0.0%
66869	Nationwide Life Ins Co	3	0.1%	1	33.3%	0	0.0%	0	0.0%
96940	Optimum Choice, Inc.	646	14.7%	391	60.5%	183	28.3%	5	0.8%

***L=Outpatient Hospital Services, Education Services, and Transportation**

APPEALS AND GRIEVANCES

CARRIER'S INTERNAL GRIEVANCE STATISTICS BY CATEGORY - 2001

NAIC #	COMPANY NAME	GRIEVANCES FILED		A. INPATIENT HOSPITAL SERVICES		B. EMERGENCY ROOM SERVICES		C. MENTAL HEALTH SERVICES	
		COMPANY TOTAL	% OF ALL COMPANIES	NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL
97268	Pacific Life & Annuity	10	0.2%	1	10.0%	0	0.0%	0	0.0%
67466	Pacific Life Ins Co	1	0.0%	0	0.0%	0	0.0%	0	0.0%
95641	Preferred Health Network	106	2.4%	10	9.4%	0	0.0%	84	79.2%
61271	Principal Life Ins Co	1	0.0%	0	0.0%	0	0.0%	0	0.0%
95040	Prudential Health Care Plan, Inc.	29	0.7%	5	17.2%	2	6.9%	0	0.0%
68241	Prudential Ins Co of America	8	0.2%	0	0.0%	0	0.0%	0	0.0%
68381	Reliance Standard Life Ins Co	3	0.1%	0	0.0%	0	0.0%	0	0.0%
67105	ReliaStar Life Ins Co	1	0.0%	0	0.0%	0	0.0%	0	0.0%
61425	Trustmark Insurance Co	21	0.5%	0	0.0%	0	0.0%	0	0.0%
80314	UNICARE Life & Health Ins Co	5	0.1%	1	20.0%	0	0.0%	1	20.0%
69744	Union Labor Life Ins Co	2	0.0%	0	0.0%	0	0.0%	0	0.0%
95253	United Concordia Dental Plans, Inc.	42	1.0%	0	0.0%	0	0.0%	0	0.0%
87566	United Concordia Ins Co	2	0.0%	0	0.0%	0	0.0%	0	0.0%
62294	United Concordia Life & Health Ins	6	0.1%	0	0.0%	0	0.0%	0	0.0%
79413	United HealthCare Ins Co	6	0.1%	0	0.0%	0	0.0%	0	0.0%
95025	United Healthcare of the Mid-Atl	68	1.6%	4	5.9%	48	70.6%	11	16.2%
69868	United of Omaha Life Ins Co	53	1.2%	1	1.9%	0	0.0%	3	5.7%
97179	United Wisconsin Life Ins Co	164	3.7%	0	0.0%	0	0.0%	0	0.0%
70319	Washington National Ins Co	1	0.0%	0	0.0%	0	0.0%	0	0.0%
	TOTAL	**4383**		**1665**		**459**		**395**	

***L=Outpatient Hospital Services, Education Services, and Transportation**

APPEALS AND GRIEVANCES

CARRIER'S INTERNAL GRIEVANCE STATISTICS BY CATEGORY - 2001

NAIC #	COMPANY NAME	D. PHYSICIAN SERVICES		E. LABORATORY, RADIOLOGY SERV		F. PHARMACY SERVICES		G. PT, OT, ST Services (incl INPAT REHAB)	
		NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL
95590	Aetna USHC(DE)/NYLCare	56	34.1%	1	0.6%	23	14.0%	10	6.1%
90611	Allianz Life Ins Co of N. America	3	100.0%	0	0.0%	0	0.0%	0	0.0%
71773	American National Life Ins Co	0	0.0%	1	100.0%	0	0.0%	0	0.0%
60836	American Republic Ins Co	0	0.0%	0	0.0%	1	100.0%	0	0.0%
61301	Ameritas Life Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
96202	Capital Care, Inc. (CareFirst BlueChoice, Inc.)	3	7.3%	2	4.9%	3	7.3%	0	0.0%
47058	CareFirst of Maryland, Inc.	60	8.5%	17	2.4%	34	4.8%	15	2.1%
80799	Celtic Life Ins Co	16	72.7%	0	0.0%	4	18.2%	0	0.0%
48119	CIGNA Dental Health of Maryland	0	0.0%	0	0.0%	0	0.0%	0	0.0%
95599	CIGNA Healthcare Mid-Atlantic, Inc	60	20.9%	14	4.9%	61	21.3%	5	1.7%
77828	Companion Life Insurance Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
62308	Connecticut General Life Insurance	111	25.5%	17	3.9%	32	7.3%	10	2.3%
93769	Conseco Medical Insurance Co	0	0.0%	0	0.0%	0	0.0%	2	28.6%
71404	Continental General Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
96460	COVENTRY (Principal HC of DE, Inc)	19	32.2%	24	40.7%	0	0.0%	0	0.0%
95574	Delmarva Health Plan, Inc.	8	36.4%	4	18.2%	1	4.5%	1	4.5%
47040	Dental Benefit Providers of MD	0	0.0%	0	0.0%	0	0.0%	0	0.0%
73288	Employers Health Ins Co	1	100.0%	0	0.0%	0	0.0%	0	0.0%
43010	Fidelity Ins Co (MD Fidelity)	12	14.0%	6	7.0%	2	2.3%	7	8.1%
70408	Fortis Benefits Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
95572	Freestate Health Plan, Inc.	45	13.5%	2	0.6%	10	3.0%	6	1.8%
95666	Geo Washington U Health Plan	1	14.3%	1	14.3%	0	0.0%	0	0.0%
68322	Great-West Life & Annuity Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
53007	Group Hosp & MedServ	19	23.8%	4	5.0%	8	10.0%	4	5.0%
64246	Guardian Life Ins Co Of America	1	1.9%	0	0.0%	0	0.0%	0	0.0%
93440	Highmark(TransGeneral)	2	100.0%	0	0.0%	0	0.0%	0	0.0%
55522	Kaiser Fndtn Health Plan-Mid-Atl	76	40.9%	17	9.1%	3	1.6%	9	4.8%
60321	MAMSI Life & Health Ins Co	28	8.1%	3	0.9%	0	0.0%	6	1.7%
96310	MD-Individual Practive Assoc.	8	5.9%	1	0.7%	0	0.0%	4	3.0%
97055	Mega Life & Health Ins. Co.	4	44.4%	2	22.2%	0	0.0%	1	11.1%
53031	Mid-Atlantic Vision Serv. Plan, Inc.	1	100.0%	0	0.0%	0	0.0%	0	0.0%
71412	Mutual of Omaha Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
66869	Nationwide Life Ins Co	0	0.0%	0	0.0%	2	66.7%	0	0.0%
96940	Optimum Choice, Inc.	39	6.0%	0	0.0%	0	0.0%	10	1.5%

***L=Outpatient Hospital Services, Education Services, and Transportation**

APPEALS AND GRIEVANCES

CARRIER'S INTERNAL GRIEVANCE STATISTICS BY CATEGORY - 2001

NAIC #	COMPANY NAME	D. PHYSICIAN SERVICES		E. LABORATORY, RADIOLOGY SERV		F. PHARMACY SERVICES		G. PT, OT, ST Services (incl INPAT REHAB)	
		NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL
97268	Pacific Life & Annuity	7	70.0%	0	0.0%	0	0.0%	0	0.0%
67466	Pacific Life Ins Co	0	0.0%	1	100.0%	0	0.0%	0	0.0%
95641	Preferred Health Network	5	4.7%	0	0.0%	3	2.8%	0	0.0%
61271	Principal Life Ins Co	0	0.0%	0	0.0%	0	0.0%	1	100.0%
95040	Prudential Health Care Plan, Inc.	17	58.6%	2	6.9%	1	3.4%	0	0.0%
68241	Prudential Ins Co of America	3	37.5%	1	12.5%	1	12.5%	0	0.0%
68381	Reliance Standard Life Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
67105	ReliaStar Life Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
61425	Trustmark Insurance Co	16	76.2%	4	19.0%	0	0.0%	0	0.0%
80314	UNICARE Life & Health Ins Co	2	40.0%	0	0.0%	1	20.0%	0	0.0%
69744	Union Labor Life Ins Co	0	0.0%	0	0.0%	0	0.0%	1	50.0%
95253	United Concordia Dental Plans, Inc.	0	0.0%	0	0.0%	0	0.0%	0	0.0%
87566	United Concordia Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
62294	United Concordia Life & Health Ins	0	0.0%	0	0.0%	0	0.0%	0	0.0%
79413	United HealthCare Ins Co	2	33.3%	0	0.0%	0	0.0%	3	50.0%
95025	United Healthcare of the Mid-Atl	1	1.5%	0	0.0%	4	5.9%	0	0.0%
69868	United of Omaha Life Ins Co	13	24.5%	1	1.9%	0	0.0%	1	1.9%
97179	United Wisconsin Life Ins Co	37	22.6%	123	75.0%	0	0.0%	3	1.8%
70319	Washington National Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	TOTAL	**676**		**248**		**194**		**99**	

***L=Outpatient Hospital Services, Education Services, and Transportation**

APPEALS AND GRIEVANCES

CARRIER'S INTERNAL GRIEVANCE STATISTICS BY CATEGORY - 2001

NAIC #	COMPANY NAME	H. SKILLED NURS FAC, Sub Acute, Nurs Home		I. DURABLE MEDICAL EQUIPMENT Services		J. PODIATRY, DENTAL, OPTOMETRY, CHIRO		K. HOME HEALTH SERVICES	
		NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL
95590	Aetna USHC(DE)/NYLCare	1	0.6%	24	14.6%	7	4.3%	1	0.6%
90611	Allianz Life Ins Co of N. America	0	0.0%	0	0.0%	0	0.0%	0	0.0%
71773	American National Life Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
60836	American Republic Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
61301	Ameritas Life Ins Co	0	0.0%	0	0.0%	21	100.0%	0	0.0%
96202	Capital Care, Inc. (CareFirst BlueChoice, Inc.)	0	0.0%	0	0.0%	0	0.0%	0	0.0%
47058	CareFirst of Maryland, Inc.	8	1.1%	9	1.3%	0	0.0%	0	0.0%
80799	Celtic Life Ins Co	0	0.0%	1	4.5%	0	0.0%	0	0.0%
48119	CIGNA Dental Health of Maryland	0	0.0%	0	0.0%	1	100.0%	0	0.0%
95599	CIGNA Healthcare Mid-Atlantic, Inc	1	0.3%	6	2.1%	6	2.1%	0	0.0%
77828	Companion Life Insurance Co	0	0.0%	0	0.0%	29	100.0%	0	0.0%
62308	Connecticut General Life Insurance	0	0.0%	10	2.3%	65	14.9%	1	0.2%
93769	Conseco Medical Insurance Co	0	0.0%	3	42.9%	0	0.0%	0	0.0%
71404	Continental General Ins Co	1	100.0%	0	0.0%	0	0.0%	0	0.0%
96460	COVENTRY (Principal HC of DE, Inc)	0	0.0%	0	0.0%	3	5.1%	0	0.0%
95574	Delmarva Health Plan, Inc.	0	0.0%	5	22.7%	0	0.0%	0	0.0%
47040	Dental Benefit Providers of MD	0	0.0%	0	0.0%	159	100.0%	0	0.0%
73288	Employers Health Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
43010	Fidelity Ins Co (MD Fidelity)	0	0.0%	1	1.2%	7	8.1%	0	0.0%
70408	Fortis Benefits Ins Co	0	0.0%	0	0.0%	2	100.0%	0	0.0%
95572	Freestate Health Plan, Inc.	5	1.5%	33	9.9%	0	0.0%	1	0.3%
95666	Geo Washington U Health Plan	0	0.0%	0	0.0%	0	0.0%	0	0.0%
68322	Great-West Life & Annuity Ins Co	0	0.0%	0	0.0%	1	100.0%	0	0.0%
53007	Group Hosp & MedServ	0	0.0%	1	1.3%	1	1.3%	0	0.0%
64246	Guardian Life Ins Co Of America	0	0.0%	0	0.0%	42	79.2%	0	0.0%
93440	Highmark(TransGeneral)	0	0.0%	0	0.0%	0	0.0%	0	0.0%
55522	Kaiser Fndtn Health Plan-Mid-Atl	4	2.2%	13	7.0%	3	1.6%	0	0.0%
60321	MAMSI Life & Health Ins Co	10	2.9%	10	2.9%	3	0.9%	0	0.0%
96310	MD-Individual Practive Assoc.	4	3.0%	3	2.2%	2	1.5%	0	0.0%
97055	Mega Life & Health Ins. Co.	0	0.0%	0	0.0%	0	0.0%	0	0.0%
53031	Mid-Atlantic Vision Serv. Plan, Inc.	0	0.0%	0	0.0%	0	0.0%	0	0.0%
71412	Mutual of Omaha Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
66869	Nationwide Life Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
96940	Optimum Choice, Inc.	4	0.6%	12	1.9%	1	0.2%	1	0.2%

***L=Outpatient Hospital Services, Education Services, and Transportation**

APPEALS AND GRIEVANCES

CARRIER'S INTERNAL GRIEVANCE STATISTICS BY CATEGORY - 2001

NAIC #	COMPANY NAME	H. SKILLED NURS FAC, Sub Acute, Nurs Home		I. DURABLE MEDICAL EQUIPMENT Services		J. PODIATRY, DENTAL, OPTOMETRY, CHIRO		K. HOME HEALTH SERVICES	
		NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL
97268	Pacific Life & Annuity	0	0.0%	0	0.0%	2	20.0%	0	0.0%
67466	Pacific Life Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
95641	Preferred Health Network	0	0.0%	4	3.8%	0	0.0%	0	0.0%
61271	Principal Life Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
95040	Prudential Health Care Plan, Inc.	0	0.0%	2	6.9%	0	0.0%	0	0.0%
68241	Prudential Ins Co of America	0	0.0%	0	0.0%	2	25.0%	1	12.5%
68381	Reliance Standard Life Ins Co	0	0.0%	0	0.0%	3	100.0%	0	0.0%
67105	ReliaStar Life Ins Co	0	0.0%	0	0.0%	1	100.0%	0	0.0%
61425	Trustmark Insurance Co	0	0.0%	0	0.0%	1	4.8%	0	0.0%
80314	UNICARE Life & Health Ins Co	0	0.0%	0	0.0%	0	0.0%	0	0.0%
69744	Union Labor Life Ins Co	0	0.0%	0	0.0%	1	50.0%	0	0.0%
95253	United Concordia Dental Plans, Inc.	0	0.0%	0	0.0%	42	100.0%	0	0.0%
87566	United Concordia Ins Co	0	0.0%	0	0.0%	2	100.0%	0	0.0%
62294	United Concordia Life & Health Ins	0	0.0%	0	0.0%	6	100.0%	0	0.0%
79413	United HealthCare Ins Co	1	16.7%	0	0.0%	0	0.0%	0	0.0%
95025	United Healthcare of the Mid-Atl	0	0.0%	0	0.0%	0	0.0%	0	0.0%
69868	United of Omaha Life Ins Co	0	0.0%	0	0.0%	34	64.2%	0	0.0%
97179	United Wisconsin Life Ins Co	0	0.0%	0	0.0%	0	0.0%	1	0.6%
70319	Washington National Ins Co	0	0.0%	1	100.0%	0	0.0%	0	0.0%
	TOTAL	**39**		**138**		**447**		**6**	

***L=Outpatient Hospital Services,**
Education Services, and
Transportation

APPEALS AND GRIEVANCES

CARRIER'S INTERNAL GRIEVANCE STATISTICS BY CATEGORY - 2001

NAIC #	COMPANY NAME	*L. OTHER	
		NUMBER	% TOTAL
95590	Aetna USHC(DE)/NYLCare	0	0.0%
90611	Allianz Life Ins Co of N. America	0	0.0%
71773	American National Life Ins Co	0	0.0%
60836	American Republic Ins Co	0	0.0%
61301	Ameritas Life Ins Co	0	0.0%
96202	Capital Care, Inc. (CareFirst BlueChoice, Inc.)	0	0.0%
47058	CareFirst of Maryland, Inc.	0	0.0%
80799	Celtic Life Ins Co	0	0.0%
48119	CIGNA Dental Health of Maryland	0	0.0%
95599	CIGNA Healthcare Mid-Atlantic, Inc	12	4.2%
77828	Companion Life Insurance Co	0	0.0%
62308	Connecticut General Life Insurance	4	0.9%
93769	Conseco Medical Insurance Co	1	14.3%
71404	Continental General Ins Co	0	0.0%
96460	COVENTRY (Principal HC of DE, Inc)	0	0.0%
95574	Delmarva Health Plan, Inc.	0	0.0%
47040	Dental Benefit Providers of MD	0	0.0%
73288	Employers Health Ins Co	0	0.0%
43010	Fidelity Ins Co (MD Fidelity)	0	0.0%
70408	Fortis Benefits Ins Co	0	0.0%
95572	Freestate Health Plan, Inc.	0	0.0%
95666	Geo Washington U Health Plan	0	0.0%
68322	Great-West Life & Annuity Ins Co	0	0.0%
53007	Group Hosp & MedServ	0	0.0%
64246	Guardian Life Ins Co Of America	0	0.0%
93440	Highmark(TransGeneral)	0	0.0%
55522	Kaiser Fndtn Health Plan-Mid-Atl	0	0.0%
60321	MAMSI Life & Health Ins Co	0	0.0%
96310	MD-Individual Practive Assoc.	0	0.0%
97055	Mega Life & Health Ins. Co.	0	0.0%
53031	Mid-Atlantic Vision Serv. Plan, Inc.	0	0.0%
71412	Mutual of Omaha Ins Co	0	0.0%
66869	Nationwide Life Ins Co	0	0.0%
96940	Optimum Choice, Inc.	0	0.0%

***L=Outpatient Hospital Services, Education Services, and Transportation**

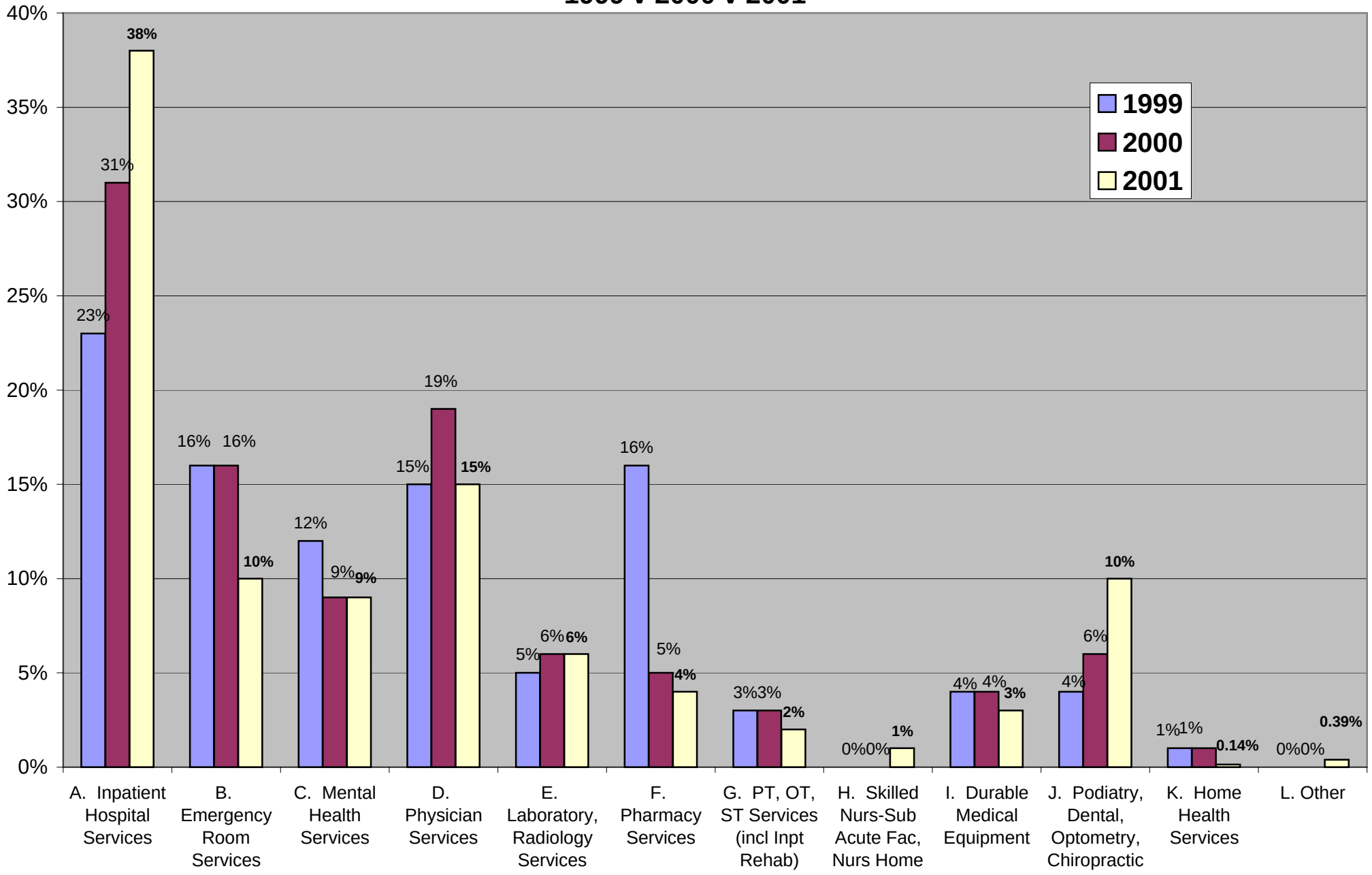
APPEALS AND GRIEVANCES

CARRIER'S INTERNAL GRIEVANCE STATISTICS BY CATEGORY - 2001

NAIC #	COMPANY NAME	*L. OTHER	
		NUMBER	% TOTAL
97268	Pacific Life & Annuity	0	0.0%
67466	Pacific Life Ins Co	0	0.0%
95641	Preferred Health Network	0	0.0%
61271	Principal Life Ins Co	0	0.0%
95040	Prudential Health Care Plan, Inc.	0	0.0%
68241	Prudential Ins Co of America	0	0.0%
68381	Reliance Standard Life Ins Co	0	0.0%
67105	ReliaStar Life Ins Co	0	0.0%
61425	Trustmark Insurance Co	0	0.0%
80314	UNICARE Life & Health Ins Co	0	0.0%
69744	Union Labor Life Ins Co	0	0.0%
95253	United Concordia Dental Plans, Inc.	0	0.0%
87566	United Concordia Ins Co	0	0.0%
62294	United Concordia Life & Health Ins	0	0.0%
79413	United HealthCare Ins Co	0	0.0%
95025	United Healthcare of the Mid-Atl	0	0.0%
69868	United of Omaha Life Ins Co	0	0.0%
97179	United Wisconsin Life Ins Co	0	0.0%
70319	Washington National Ins Co	0	0.0%
	TOTAL	**17**	

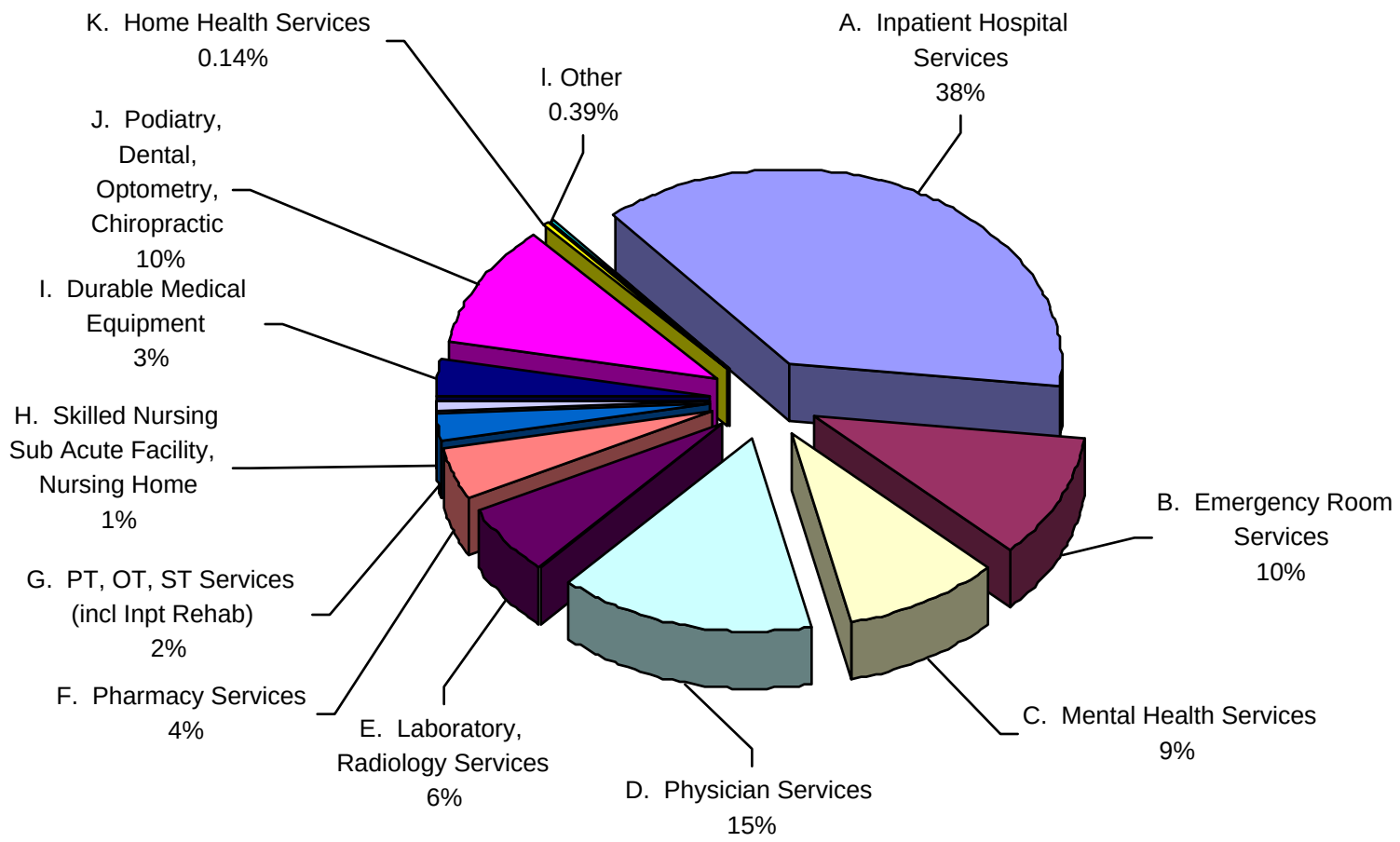
***L=Outpatient Hospital Services, Education Services, and Transportation**

GRIEVANCES REPORTED BY CARRIERS
TYPE OF SERVICES AS A PERCENTAGE OF TOTAL GRIEVANCES
1999 v 2000 v 2001



COMPARISON 1999 V 2000del.xls, Carrier Griev 99-00

CARRIER INTERNAL GRIEVANCES REPORTED BY CATEGORY - 2001



APPEALS AND GRIEVANCES

CARRIER'S AGGREGATE INTERNAL GRIEVANCE STATISTICS - 2001

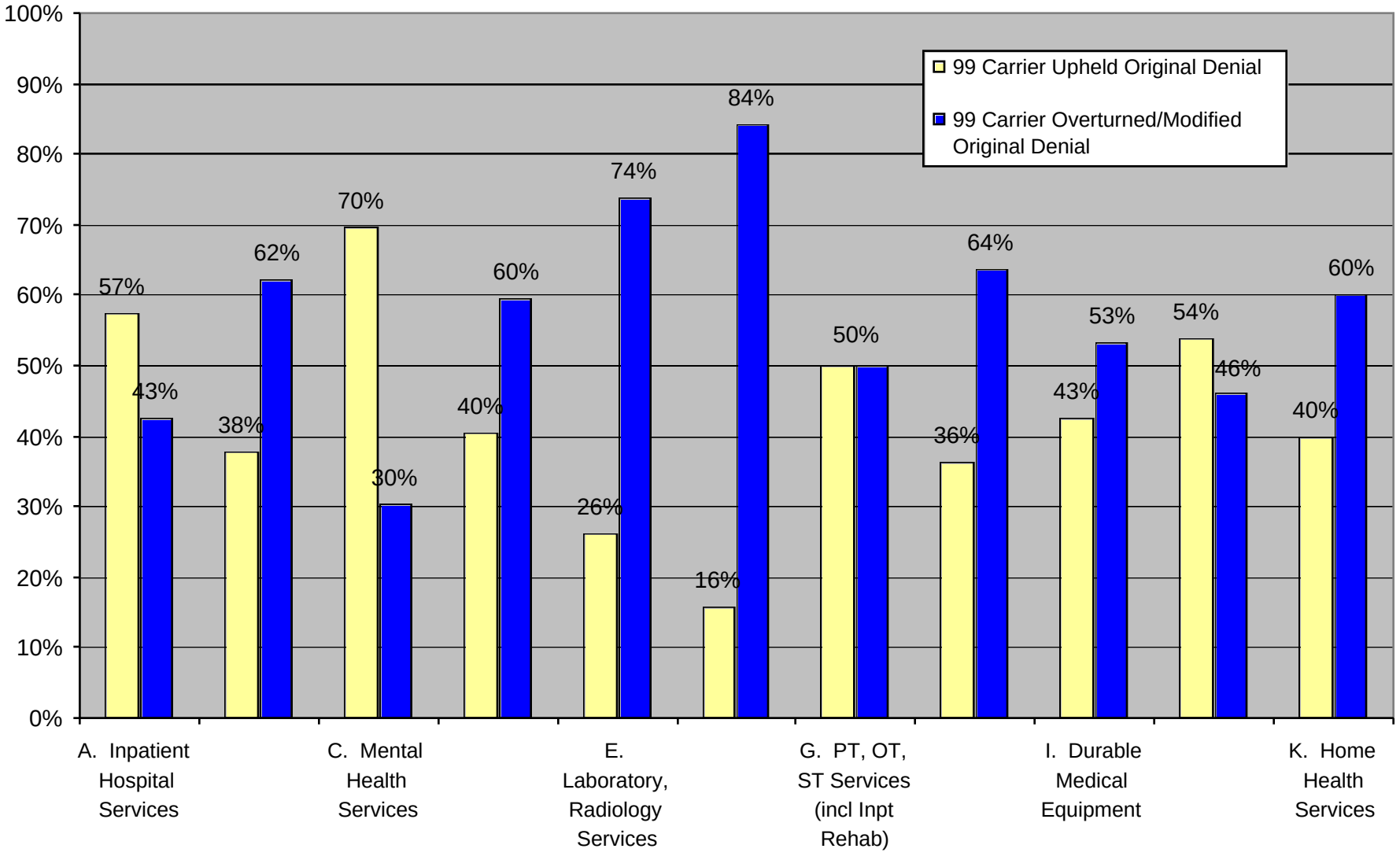
NAIC #	COMPANY NAME	GRIEVANCES FILED		ORIGINAL DECISION OF INSURANCE COMPANY WAS…					
		COMPANY TOTAL	% OF ALL COMPANIES	UPHELD		OVERTURNED		MODIFIED	
				NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL
95590	Aetna USHC(DE)/NYLCare	164	3.7%	52	31.7%	106	64.6%	6	3.7%
90611	Allianz Life Ins Co of N. America	3	0.1%	2	66.7%	1	33.3%	0	0.0%
71773	American National Life Ins Co	1	0.0%	0	0.0%	1	100.0%	0	0.0%
60836	American Republic Ins Co	1	0.0%	0	0.0%	1	100.0%	0	0.0%
61301	Ameritas Life Ins Co	21	0.5%	19	90.5%	2	9.5%	0	0.0%
96202	Capital Care, Inc. (CareFirst BlueChoice, Inc.)	41	0.9%	29	70.7%	11	26.8%	1	2.4%
47058	CareFirst of Maryland, Inc.	708	16.2%	407	57.5%	194	27.4%	107	15.1%
80799	Celtic Life Ins Co	22	0.5%	13	59.1%	9	40.9%	0	0.0%
48119	CIGNA Dental Health of Maryland, Inc.	1	0.0%	1	100.0%	0	0.0%	0	0.0%
95599	CIGNA Healthcare Mid-Atlantic, Inc	287	6.5%	98	34.1%	165	57.5%	24	8.4%
77828	Companion Life Insurance Co	29	0.7%	5	17.2%	22	75.9%	2	6.9%
62308	Connecticut General Life Insurance	436	9.9%	163	37.4%	241	55.3%	32	7.3%
93769	Conseco Medical Insurance Co	7	0.2%	5	71.4%	2	28.6%	0	0.0%
71404	Continental General Ins Co	1	0.0%	0	0.0%	1	100.0%	0	0.0%
96460	COVENTRY (Principal HC of DE, Inc)	59	1.3%	8	13.6%	51	86.4%	0	0.0%
95574	Delmarva Health Plan, Inc.	22	0.5%	14	63.6%	7	31.8%	1	4.5%
47040	Dental Benefit Providers of MD	159	3.6%	67	42.1%	70	44.0%	22	13.8%
73288	Employers Health Ins Co	1	0.0%	1	100.0%	0	0.0%	0	0.0%
43010	Fidelity Ins Co (MD Fidelity)	86	2.0%	23	26.7%	48	55.8%	15	17.4%
70408	Fortis Benefits Ins Co	2	0.0%	1	50.0%	1	50.0%	0	0.0%
95572	Freestate Health Plan, Inc.	333	7.6%	162	48.6%	129	38.7%	42	12.6%
95666	Geo Washington U Health Plan	7	0.2%	2	28.6%	5	71.4%	0	0.0%
68322	Great-West Life & Annuity Ins Co	1	0.0%	0	0.0%	1	100.0%	0	0.0%
53007	Group Hosp & MedServ	80	1.8%	44	55.0%	34	42.5%	2	2.5%
64246	Guardian Life Ins Co Of America	53	1.2%	13	24.5%	34	64.2%	6	11.3%
93440	Highmark(TransGeneral)	2	0.0%	2	100.0%	0	0.0%	0	0.0%
55522	Kaiser Fndtn Health Plan-Mid-Atl	186	4.2%	53	28.5%	133	71.5%	0	0.0%
60321	MAMSI Life & Health Ins Co	344	7.8%	217	63.1%	97	28.2%	30	8.7%
96310	MD-Individual Practive Assoc.	135	3.1%	83	61.5%	39	28.9%	13	9.6%
97055	Mega Life & Health Ins. Co.	9	0.2%	6	66.7%	3	33.3%	0	0.0%
53031	Mid-Atlantic Vision Serv. Plan, Inc.	1	0.0%	1	100.0%	0	0.0%	0	0.0%
71412	Mutual of Omaha Ins Co	3	0.1%	1	33.3%	1	33.3%	1	33.3%
66869	Nationwide Life Ins Co	3	0.1%	1	33.3%	2	66.7%	0	0.0%
96940	Optimum Choice, Inc.	646	14.7%	405	62.7%	179	27.7%	62	9.6%
97268	Pacific Life & Annuity	10	0.2%	2	20.0%	8	80.0%	0	0.0%
67466	Pacific Life Ins Co	1	0.0%	0	0.0%	1	100.0%	0	0.0%

APPEALS AND GRIEVANCES

CARRIER'S AGGREGATE INTERNAL GRIEVANCE STATISTICS - 2001

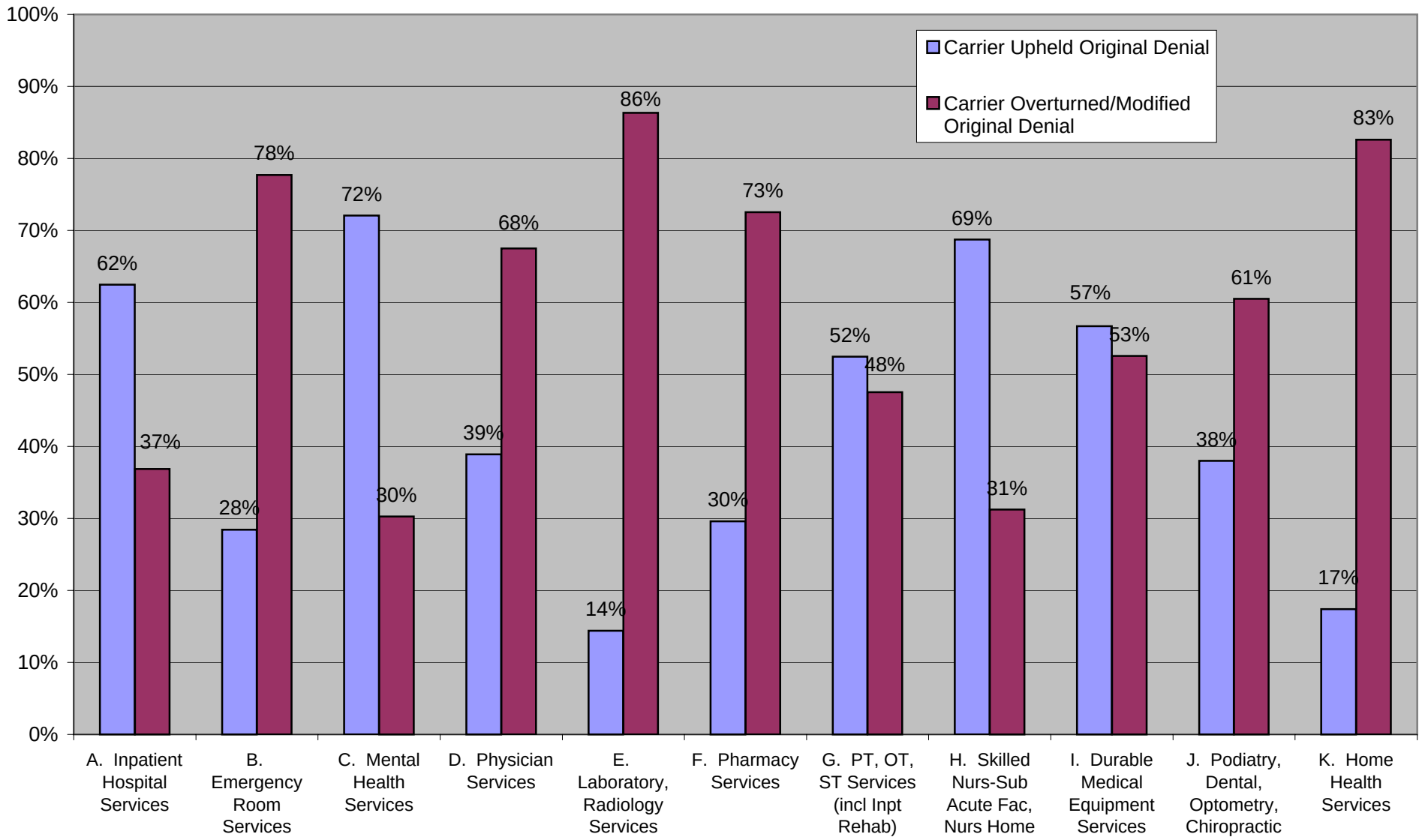
NAIC #	COMPANY NAME	GRIEVANCES FILED		ORIGINAL DECISION OF INSURANCE COMPANY WAS...					
		COMPANY TOTAL	% OF ALL COMPANIES	UPHELD		OVERTURNED		MODIFIED	
				NUMBER	% TOTAL	NUMBER	% TOTAL	NUMBER	% TOTAL
95641	Preferred Health Network	106	2.4%	70	66.0%	25	23.6%	11	10.4%
61271	Principal Life Ins Co	1	0.0%	0	0.0%	1	100.0%	0	0.0%
95040	Prudential Health Care Plan, Inc.	29	0.7%	3	10.3%	26	89.7%	0	0.0%
68241	Prudential Ins Co of America	8	0.2%	6	75.0%	2	25.0%	0	0.0%
68381	Reliance Standard Life Ins Co	3	0.1%	2	66.7%	1	33.3%	0	0.0%
67105	ReliaStar Life Ins Co	1	0.0%	0	0.0%	1	100.0%	0	0.0%
61425	Trustmark Insurance Co	21	0.5%	13	61.9%	8	38.1%	0	0.0%
80314	UNICARE Life & Health Ins Co	5	0.1%	5	100.0%	0	0.0%	0	0.0%
69744	Union Labor Life Ins Co	2	0.0%	2	100.0%	0	0.0%	0	0.0%
95253	United Concordia Dental Plans, Inc.	42	1.0%	14	33.3%	25	59.5%	3	7.1%
87566	United Concordia Ins Co	2	0.0%	1	50.0%	1	50.0%	0	0.0%
62294	United Concordia Life & Health Ins	6	0.1%	2	33.3%	4	66.7%	0	0.0%
79413	United HealthCare Ins Co	6	0.1%	6	100.0%	0	0.0%	0	0.0%
95025	United Healthcare of the Mid-Atl	68	1.6%	35	51.5%	33	48.5%	0	0.0%
69868	United of Omaha Life Ins Co	53	1.2%	19	35.8%	34	64.2%	0	0.0%
97179	United Wisconsin Life Ins Co	164	3.7%	1	0.6%	158	96.3%	5	3.0%
70319	Washington National Insurance Company	1	0.0%	1	100.0%	0	0.0%	0	0.0%
	TOTAL	**4383**		**2080**		**1918**		**385**	

INTERNAL GRIEVANCE - CARRIER DISPOSITION REPORTED BY SERVICE - 1999



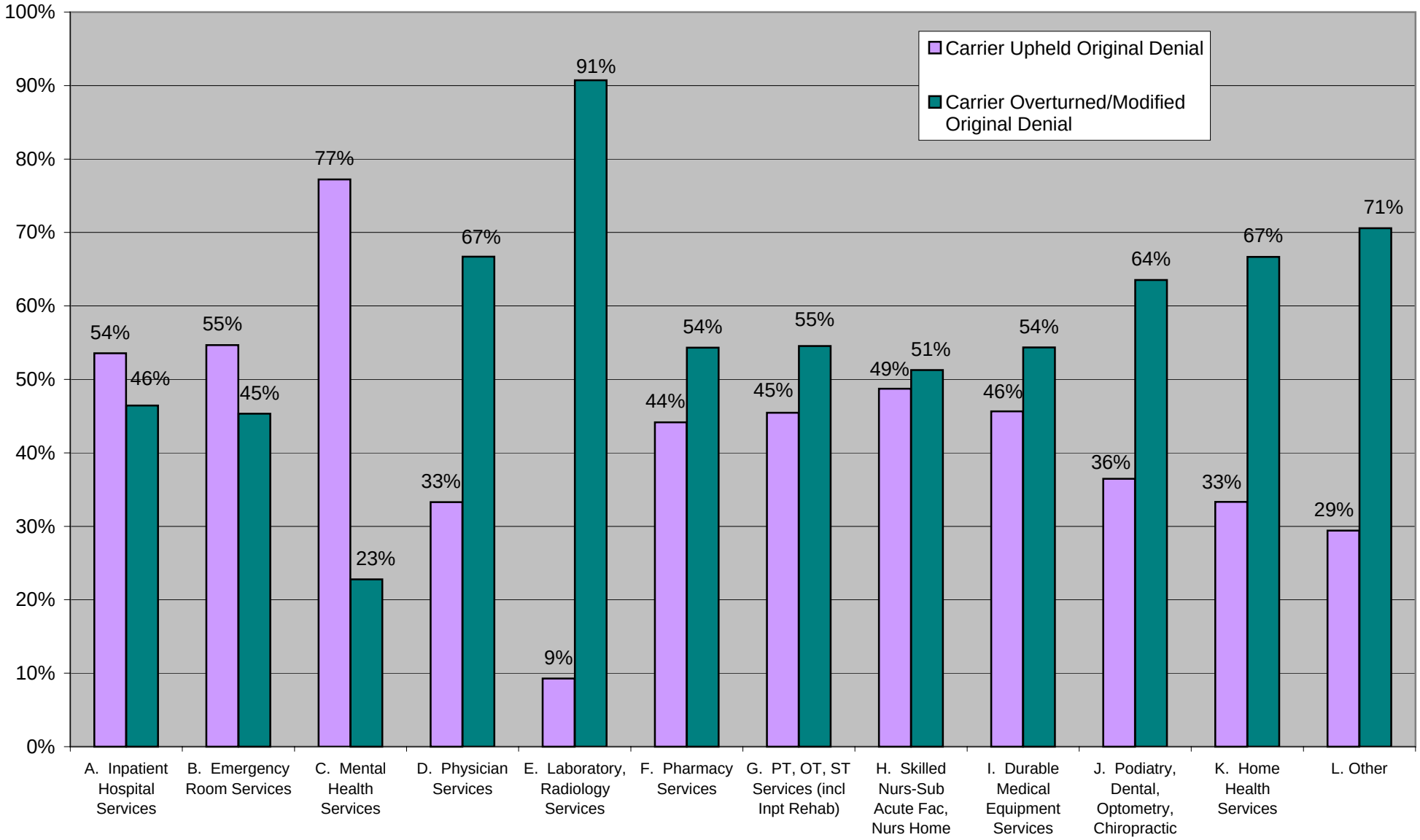
2001-CHARTS-TABLESdelrev.xls, Carrier-Internal-SubActs-99

INTERNAL GRIEVANCE - CARRIER DISPOSITION REPORTED BY SERVICE - 2000



2001-CHARTS-TABLESdelrev.xls, Carrier-Internal-ActionsSubs-00

INTERNAL GRIEVANCE - CARRIER DISPOSITION REPORTED BY SERVICE - 2001



***L. Outpatient Hospital Services, Education Services, and Transportation**

APPEALS AND GRIEVANCES

INTERNAL GRIEVANCES FILED CONSIDERED EMERGENCY CASES AS REPORTED BY CARRIER - 2001

NAIC #	COMPANY* NAME	"EMERGENCIES" TOTAL	UPHELD		OVERTURNED		MODIFIED	
			Number	Percent	Number	Percent	Number	Percent
96202	Capital Care, Inc. (CareFirst BlueChoice, Inc.)	26	22	84.6%	3	11.5%	1	3.8%
47058	CareFirst of Maryland, Inc.	86	77	89.5%	9	10.5%	0	0.0%
95599	CIGNA Healthcare Mid-Atlantic, Inc	5	3	60.0%	1	20.0%	1	20.0%
62308	Connecticut General Life Insurance	6	6	100.0%	0	0.0%	0	0.0%
95572	Freestate Health Plan, Inc.	38	34	89.5%	4	10.5%	0	0.0%
53007	Group Hosp & MedServ	30	24	80.0%	6	20.0%	0	0.0%
55522	Kaiser Fndtn Health Plan-Mid-Atl	15	8	53.3%	7	46.7%	0	0.0%
96310	MD-Individual Practive Assoc.	1	0	0.0%	1	100.0%	0	0.0%
96940	Optimum Choice, Inc.	6	3	50.0%	3	50.0%	0	0.0%
95641	Preferred Health Network	63	42	66.7%	13	20.6%	8	12.7%
	TOTAL	**276**	**219**	**79.3%**	**47**	**17.0%**	**10**	**3.6%**

***This chart only includes carriers who had grievances which were considered emergency cases during calendar year 2001.**

UP - UPHELD

OV - OVERTURNED

Mod - MODIFIED

APPEALS AND GRIEVANCES
EMERGENCY CASES - RESOLUTION TIME* - 2001

NAIC #	COMPANY** NAME	EMERGENCY CASES - RESOLUTION TIME*			
		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
96202	Capital Care, Inc. (CareFirst BlueChoice, Inc.)	27	18	14	24
47058	CareFirst of Maryland, Inc.	13	9	9	24
95599	CIGNA Healthcare Mid-Atlantic, Inc.	0	0	0	37
62308	Connecticut General Life Insurance	36	0	0	0
95572	Freestate Health Plan, Inc.	9	10	10	0
53007	Group Hosp & MedServ	24	19	18	24
55522	Kaiser Fndtn Health Plan-Mid-Atl	29	14	10	10
96310	MD-Individual Practive Assoc.	24	0	0	0
96940	Optimum Choice, Inc.	24	48	24	0
95641	Preferred Health Network	24	24	24	24

****This report only includes carriers who had grievances which were considered emergency cases during calendar year 2001**

***Reported as hours**

APPEALS AND GRIEVANCES
NON - EMERGENCY CASES - RESOLUTION TIME* - 2001

NAIC #	COMPANY NAME	NON-EMERGENCY CASES - RESOLUTION TIME*			
		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
95590	Aetna USHC(DE)/NYLCare	18	18	15	16
90611	Allianz Life Ins Co of N. America	0	38	15	0
71773	American National Life Ins Co	13	0	0	0
60836	American Republic Ins Co	0	0	11	0
61301	Ameritas Life Ins Co	2	3	4	1
96202	Capital Care, Inc. (CareFirst BlueChoice, Inc.)	9	20	12	25
47058	CareFirst of Maryland, Inc.	27	39	34	37
80799	Celtic Life Ins Co	26	24	23	15
48119	CIGNA Dental Health of Maryland, Inc.	0	0	0	28
95599	CIGNA Healthcare Mid-Atlantic, Inc	15	21	23	19
62308	Connecticut General Life Insurance	10	15	17	16
93769	Conseco Medical Insurance Co	11	0	12	0
71404	Continental General Ins Co	0	9	0	0
96460	COVENTRY (Principal HC of DE, Inc)	12	24	14	5
95574	Delmarva Health Plan, Inc.	14	28	45	36
47040	Dental Benefit Providers of MD	5	5	3	5
73288	Employers Health Ins Co	10	0	0	0
43010	Fidelity Ins Co (MD Fidelity)	19	20	23	19
70408	Fortis Benefits Ins Co	0	3	0	1
95572	Freestate Health Plan, Inc.	28	38	31	28
95666	Geo Washington U Health Plan	0	23	4	17
53007	Group Hosp & MedServ	47	22	53	24
64246	Guardian Life Ins Co Of America	0	2	1	12
93440	Highmark(TransGeneral)	5	0	0	0
55522	Kaiser Fndtn Health Plan-Mid-Atl	30	29	31	29
60321	MAMSI Life & Health Ins Co	36	37	24	23
96310	MD-Individual Practive Assoc.	37	34	26	21
97055	Mega Life & Health Ins. Co.	13	15	23	10
53031	Mid-Atlantic Vision Serv. Plan, Inc.	0	1	0	0
71412	Mutual of Omaha Ins Co	0	17	3	0
66869	Nationwide Life Ins Co	0	18	17	0
96940	Optimum Choice, Inc.	36	37	24	27
97268	Pacific Life & Annuity	49	21	27	0
67466	Pacific Life Ins Co	0	31	0	0
95641	Preferred Health Network	22	22	23	22
61271	Principal Life Ins Co	9	0	0	0

***Reported as Calendar Days**

APPEALS AND GRIEVANCES
NON - EMERGENCY CASES - RESOLUTION TIME* - 2001

NAIC #	COMPANY NAME	NON-EMERGENCY CASES - RESOLUTION TIME*			
		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
95040	Prudential Health Care Plan, Inc.	30	33	22	8
68241	Prudential Ins Co of America	13	0	13	0
68381	Reliance Standard Life Ins Co	3	4	0	0
67105	ReliaStar Life Ins Co	0	7	0	0
61425	Trustmark Insurance Co	23	30	0	0
80314	UNICARE Life & Health Insurance Company	0	0	14	4
69744	Union Labor Life Ins Co	14	0	0	0
95253	United Concordia Dental Plans, Inc.	11	11	0	0
87566	United Concordia Ins Co	2	3	0	0
62294	United Concordia Life & Health Ins	3	3	0	0
79413	United HealthCare Ins Co	13	10	11	30
95025	United Healthcare of the Mid-Atl	22	40	26	31
69868	United of Omaha Life Ins Co	10	13	12	17
97179	United Wisconsin Life Ins Co	26	19	18	15
70319	Washington National Insurance Company	0	0	10	0

***Reported as Calendar Days**

APPEALS AND GRIEVANCES

GRIEVANCES FILED INVOLVING HOSPITAL LENGTH OF STAY/DENIAL OF HOSPITAL DAYS - 2001

NAIC #	COMPANY* NAME	HOSPITAL LOS TOTAL	UPHELD		OVERTURNED		MODIFIED	
			Number	Percent	Number	Percent	Number	Percent
95590	Aetna USHC(DE)/NYLCare	26	11	42.3%	13	50.0%	2	7.7%
96202	Capital Care, Inc., (CareFirst BlueChoice, Inc.)	29	23	79.3%	5	17.2%	1	3.4%
47058	CareFirst of Maryland, Inc.	443	238	53.7%	103	23.3%	102	23.0%
95599	CIGNA Healthcare Mid-Atlantic, Inc	110	41	37.3%	48	43.6%	21	19.1%
62308	Connecticut General Life Insurance	134	52	38.8%	64	47.8%	18	13.4%
93769	Conseco Medical Insurance Co	1	1	100.0%	0	0.0%	0	0.0%
20443	Continental Casualty Company	2	1	50.0%	1	50.0%	0	0.0%
96460	COVENTRY (Principal HC of DE, Inc)	15	12	80.0%	3	20.0%	0	0.0%
95574	Delmarva Health Plan, Inc.	2	2	100.0%	0	0.0%	0	0.0%
43010	Fidelity Ins Co (MD Fidelity)	1	0	0.0%	1	100.0%	0	0.0%
95572	Freestate Health Plan, Inc.	170	82	48.2%	49	28.8%	39	22.9%
95666	Geo Washington U Health Plan	2	0	0.0%	2	100.0%	0	0.0%
53007	Group Hosp & MedServ	32	23	71.9%	9	28.1%	0	0.0%
64246	Guardian Life Ins Co Of America	9	1	11.1%	5	55.6%	3	33.3%
55522	Kaiser Fndtn Health Plan-Mid-Atl	5	3	60.0%	2	40.0%	0	0.0%
60321	MAMSI Life & Health Ins Co	181	115	63.5%	38	21.0%	28	15.5%
96310	MD-Individual Practive Assoc.	100	68	68.0%	19	19.0%	13	13.0%
71412	Mutual of Omaha Ins Co	1	0	0.0%	0	0.0%	1	100.0%
66869	Nationwide Life Ins Co	1	1	100.0%	0	0.0%	0	0.0%
96940	Optimum Choice, Inc.	391	243	62.1%	88	22.5%	60	15.3%
95641	Preferred Health Network	34	24	70.6%	5	14.7%	5	14.7%
95040	Prudential Health Care Plan, Inc.	5	1	20.0%	4	80.0%	0	0.0%
80314	UNICARE Life & Health Insurance Company	2	2	100.0%	0	0.0%	0	0.0%
95025	United Healthcare of the Mid-Atl	6	3	50.0%	3	50.0%	0	0.0%
	TOTAL	**1702**	**947**	**55.6%**	**462**	**27.1%**	**293**	**17.2%**

UP - UPHELD
OV - OVERTURNED
Mod - MODIFIED

***This chart only includes those carriers who had grievances involving hospital length of stay during calendar year 2001.**

Appeal And Grievance Statistics
Dispositions Of Complaints Filed
January 1, 2001 – December 31, 2001

COMPLAINTS FILED 1312

NO JURISDICTION 469

Referred to DOL (Self-funded/ERISA)	246
Referred to OPM (Federal Employee)	60
Referred to Medicaid	27
Referred to Medicare	28
Referred to Insurance Department In Another State	81
Referred to Other*	27

*Includes complaints referred to Workers Compensations Commissioner, DHMH if issue is exclusively quality of care, Board of Physicians Quality Assurance.

COMPLAINT WITHDRAWN 30

INSUFFICIENT INFORMATION 99

NO ACTION REQUIRED 68

Includes cases transferred to Life & Health, Duplicate file, Advised Complainant

COMPLAINANT FAILED TO EXHAUST INTERNAL GRIEVANCE PROCESS 254

CARRIER REVERSED ITSELF DURING INVESTIGATION 165

CARRIER UPHELD BY MIA 168

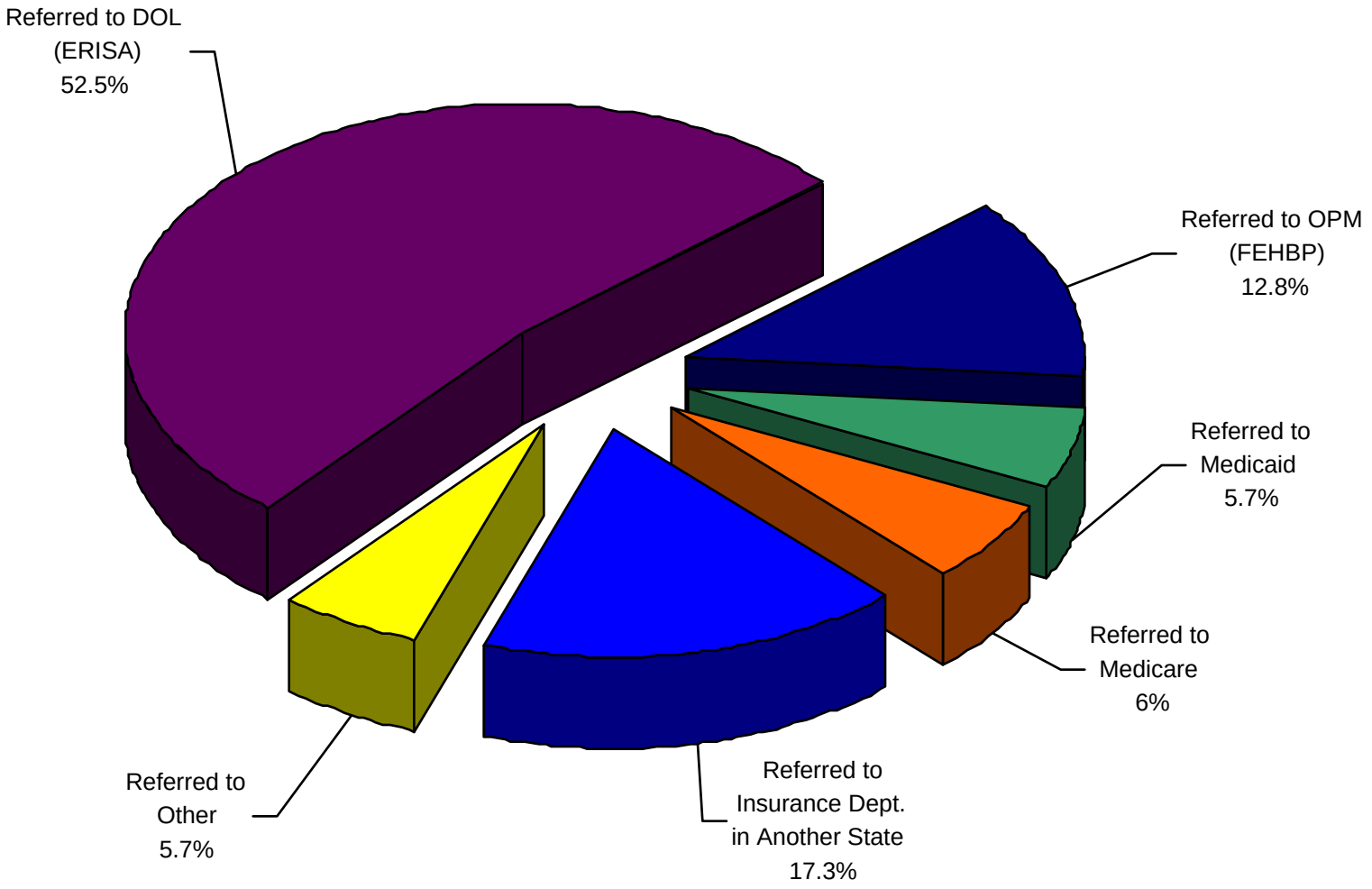
CARRIER REVERSED BY MIA 50*

CARRIER MODIFIED BY MIA 7

COMPLIANCE ORDER 2

* - One of these cases was based on three individual's complaints

Appeals & Grievance
No Jurisdiction
January 2001 - December 2001



APPEALS & GRIEVANCE
DISPOSITION OF CASES
FORWARDED TO DHMH
BY THE APPEALS & GRIEVANCE UNIT
JANUARY - DECEMBER 2001

Description	Complaints Forwarded	
	Number	Percent
Total Cases Forwarded to DHMH by the Appeals & Grievance Unit*	**53**	**100%**
Categories of Complaints Referred to DHMH:		
- Mixed jursidiction - DHMH & MIA investigations	41	77%
- Complaint solely within DHMH jursidiction	4	8%
- DHMH determined that it has no jurisidction	8	15%

***** This number does not include cases which are forwarded to DHMH by the Life & Health Section of the Insurance Administration.

SUMMARY OF APPEALS AND GRIEVANCE
COMPLAINTS INVESTIGATED BY MIA
LISTED BY CARRIER
JANUARY - DECEMBER 2001

Carrier	COMPLAINTS INVESTIGATED		Carrier Upheld by MIA		Carrier Reversed by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
	Total	Percent	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
Aetna	29	7%	10	35%	5	17%	0	0%	14	48%
American Republic	1	0%	0	0%	0	0%	0	0%	1	100%
BCBS of Maryland	92	23%	38	41%	8	9%	3	3%	43	47%
Capital Care	2	1%	0	0%	2	100%	0	0%	0	0%
CareFirst Blue Choice, Inc.	2	1%	0	0%	0	0%	0	0%	2	100%
CIGNA Dental	1	0%	0	0%	0	0%	0	0%	1	100%
CIGNA	19	5%	7	37%	2	10%	0	0%	10	53%
Companion Life	1	0%	0	0%	0	0%	0	0%	1	100%
Connecticut General	2	1%	1	50%	0	0%	0	0%	1	50%
Coventry	6	2%	1	17%	1	17%	0	0%	4	66%
Delmarva	1	0%	1	100%	0	0%	0	0%	0	0%
Dental Benefit Providers	2	1%	1	50%	1	50%	0	0%	0	0%
Educators Mutual	1	0%	0	0%	0	0%	0	0%	1	100%
Fidelity Ins Co	5	1%	1	20%	2	40%	0	0%	2	40%
Fortis Benefits	1	0%	1	100%	0	0%	0	0%	0	0%
Freestate	24	6%	8	33%	1	4%	0	0%	15	63%
George Wash. Univ. Health	6	2%	2	33%	1	17%	0	0%	3	50%
Group Hosp. & Med Services	7	2%	2	28.5%	2	28.5%	0	0%	3	43%
Guardian	2	1%	1	50%	0	0%	0	0%	1	50%
Kaiser Permanente	12	3%	8	66%	2	17%	0	0%	2	17%
MAMSI	50	13%	36	72%	3	6%	0	0%	11	22%
MD IPA	12	3%	6	50%	4	33%	0	0%	2	17%
Mega Life & Health	1	0%		0%		0%	0	0%	1	100%
Metropolitan Life	1	0%	1	100%	0	0%	0	0%	0	0%
Monumental Life	1	0%	1	100%	0	0%	0	0%	0	0%
Mutual of Omaha	2	1%	0	0%	0	0%	0	0%	2	100%
Optimum Choice	57	15%	28	49%	8	14%	0	0%	21	37%

SUMMARY OF APPEALS AND GRIEVANCE
COMPLAINTS INVESTIGATED BY MIA
LISTED BY CARRIER
JANUARY - DECEMBER 2001

Carrier	COMPLAINTS INVESTIGATED		Carrier Upheld by MIA		Carrier Reversed by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
	Total	Percent	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
PHN HMO	21	5%	5	24%	6	28.5%	4	19%	6	28.5%
Prudential	10	3%	4	40%	0	0%	0	0%	6	60%
Prison Health	1	0%		0%		0%	0	0%	1	100%
Reliance	1	0%		0%		0%	0	0%	1	100%
United HealthCare	13	3%	4	31%	0	0%	0	0%	9	69%
United Concordia-Dental	3	1%	1	33.3%	1	33.3%	0	0%	1	33.3%
Washington National	1	0%	0	0%	1	100%	0	0%	0	0%
TOTAL	**390**	100%	**168**	43%	**50**	13%	**7**	2%	**165**	42%

* In addition to the 390 complaints which were investigated, the Administration issued Orders against PHN-HMO, Inc. and Connecticut General Life Insurance Company for their failure to comply with the statutory notice provisions. Therefore, the total number of cases where the Administration took action equals 392.

SUMMARY OF APPEALS AND GRIEVANCE
COMPLAINTS INVESTIGATED BY MIA
LISTED BY SERVICE
JANUARY - DECEMBER 2001

Type of Procedure	Carrier Code**	Total	Carrier Upheld by MIA		Carrier Reversed by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
			Number	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
Acupuncture	D	1	1	100%	0	0%	0	0%	0	0%
Assisted Living	H	1	1	100%	0	0%	0	0%	0	0%
Breast Reduction	D	1	0	0%	0	0%	0	0%	1	100%
Claim Payment	L	3	0	0%	0	0%	0	0%	3	100%
Clinical Trial	D	1	0	0%	0	0%	0	0%	1	100%
Coordination of Benefits	L	2	1	50%	0	0%	0	0%	1	50%
Denial of Claim	L	11	4	36%	0	0%	0	0%	7	64%
Denial of Hospital Days	A	27	11	41%	8	29.5%	0	0%	8	29.5%
Dental	J	23	9	39%	2	9%	0	0%	12	52%
Durable Medical Equipment	I	15	7	47%	2	13%	0	0%	6	40%
Educational Services	L	1	1	100%	0	0%	0	0%	0	0%
Emergency Treatment	B	26	13	50%	0	0%	0	0%	13	50%
Experimental	D	3	3	100%	0	0%	0	0%	0	0%
Home Health Care	K	1	0	0%	0	0%	0	0%	1	100%
Hospital Length of Stay	A	2	1	50%	0	0%	0	0%	1	50%
Inpatient Rehabilitation	G	2	1	50%	0	0%	0	0%	1	50%
Lab, Imaging, Testing	E	10	6	60%	0	0%	0	0%	4	40%
Mental Health (Inpatient) Services	C	15	3	20%	3	20%	1	7%	8	53%
Mental Health (Outpatient) Services	C	12	1	8.33%	0	0%	1	8.33%	10	83.33%
Out Patient Rehab	G	1	0	0%	0	0%	0	0%	1	100%
Pharmacy	F	49	25	51%	5	10%	0	0%	19	39%
Physical Therapy	G	9	6	67%	0	0%	0	0%	3	33%
Physician Services	D	122	56	46%	17	14%	0	0%	49	40%
Policy Coverages	L	1	0	0%	0	0%	0	0%	1	100%
PT, OT, Speech Therapy	G	2	1	50%	0	0%	0	0%	1	50%
Quality of Care	D	1	0	0%	0	0%	0	0%	1	100%
Rehabilation Services	G	1	0	0%	0	0%	0	0%	1	100%

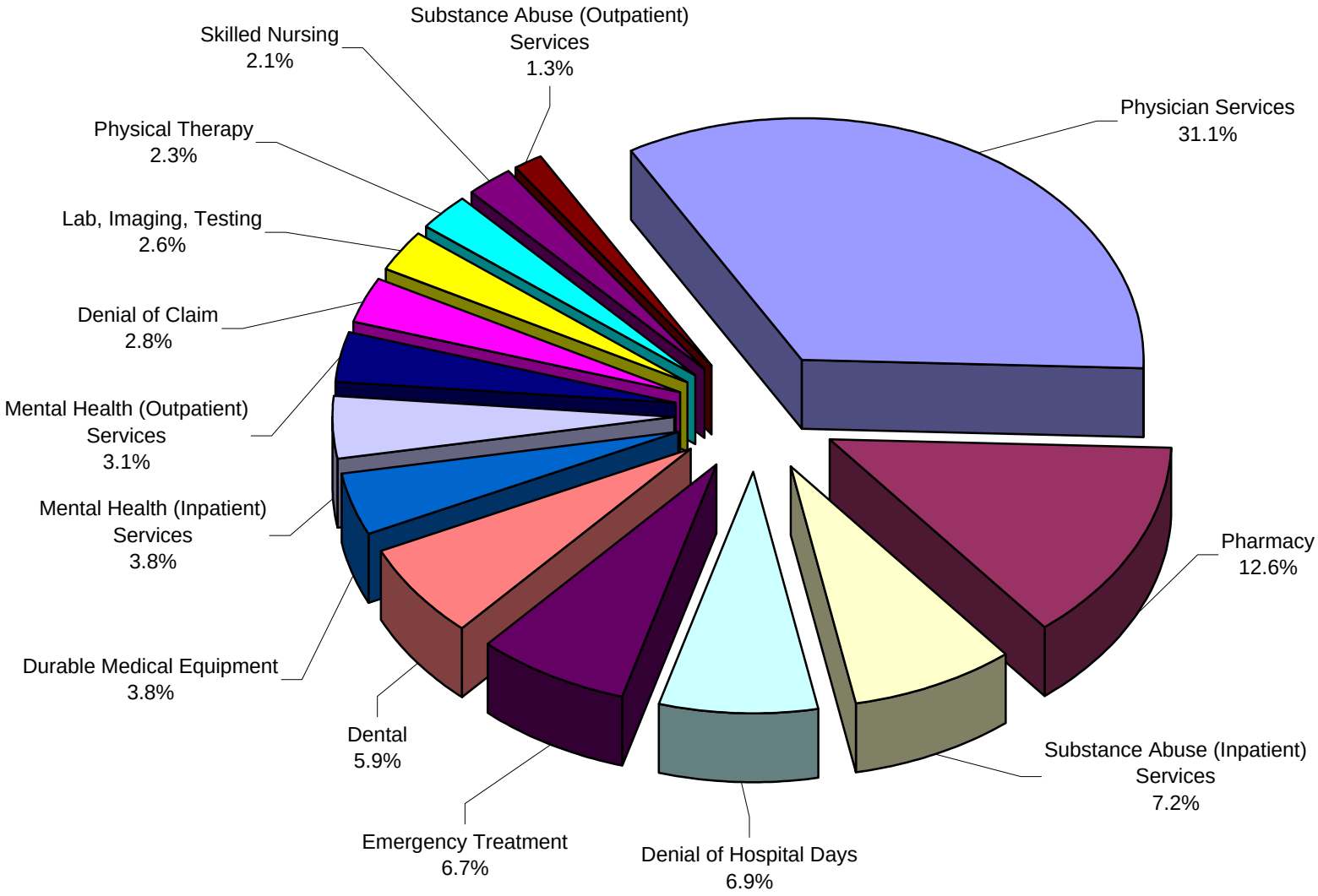
SUMMARY OF APPEALS AND GRIEVANCE
COMPLAINTS INVESTIGATED BY MIA
LISTED BY SERVICE
JANUARY - DECEMBER 2001

Type of Procedure	Carrier Code**	Total	Carrier Upheld by MIA		Carrier Reversed by MIA		Carrier Modified by MIA		Carrier Reversed Itself During Investigation	
			Number	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
Review Carrier's Criteria	L	1	1	100%	0	0%	0	0%	0	0%
Skilled Nursing	H	8	1	12.5%	2	25%	0	0%	5	62.5%
Speech Therapy	G	3	0	0%	0	0%	0	0%	3	100%
Substance Abuse (Inpatient) Services	C	28	12	43%	10	36%	4	14%	2	7%
Substance Abuse (Outpatient) Services	C	5	2	40%	1	20%	1	20%	1	20%
Transportation Services	L	2	1	50%	0	0%	0	0%	1	50%
TOTAL		**390***	**168**	43%	**50**	13%	**7**	2%	**165**	42%

* In addition to the 390 complaints which were investigated, the Administration issued Orders against PHN-HMO, Inc. and Connecticut General Life Insurance Company for their failure to comply with the statutory notice provisions. Therefore, the total number of cases where the Administration took action equals 392.

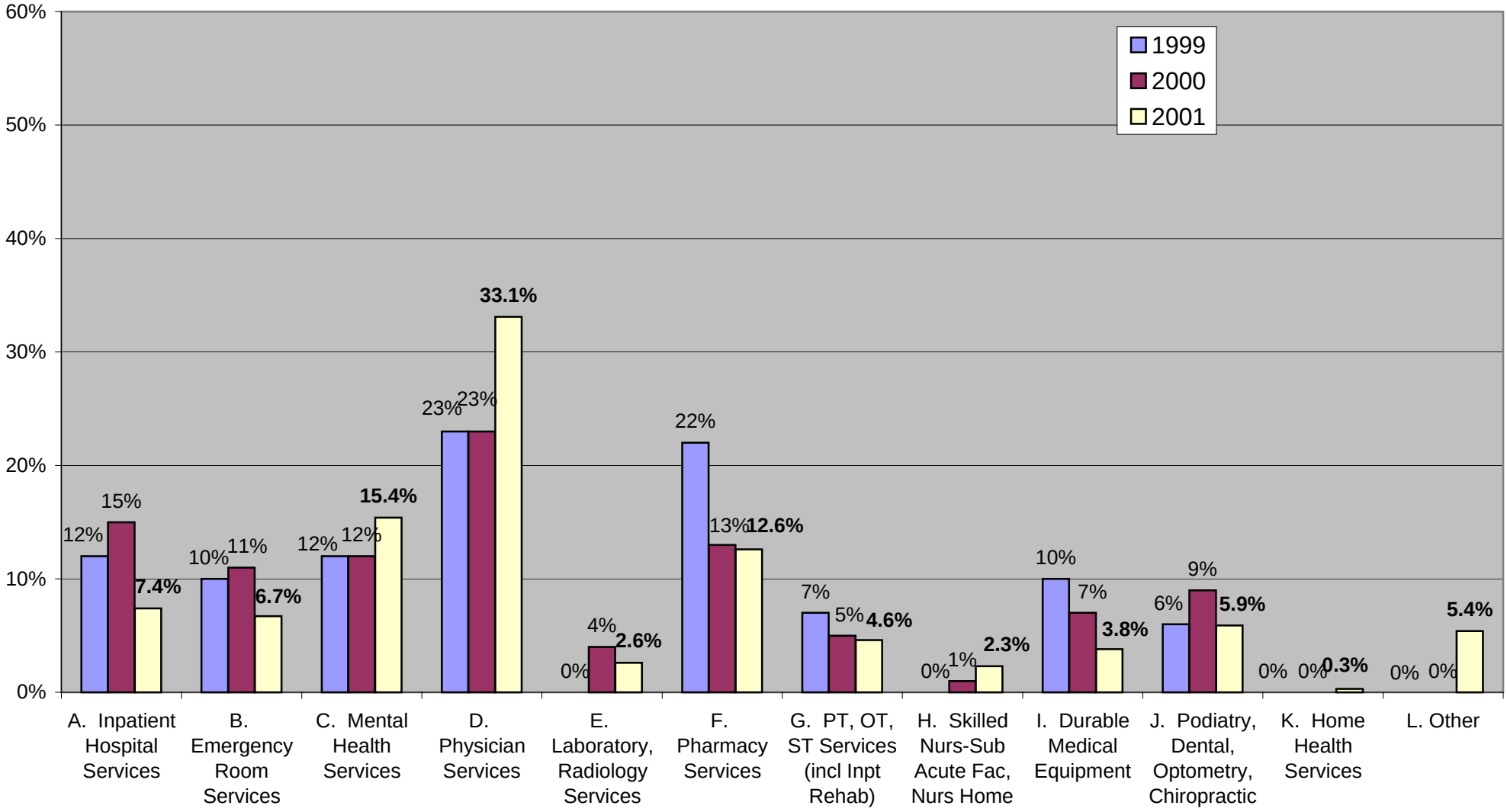
** All carrier data is divided into categories A-L. The MIA's data is more specific in nature. All charts which compare Carrier and MIA data have combined the MIA categories to fit within the carrier's A-L categories. The letters above identify which MIA category corresponds to the carrier code.

MIA COMPLAINTS INVESTIGATED BY CATEGORY - 2001



*These statistics do not include those services that were less than percert of the total.

COMPLAINTS INVESTIGATED BY MIA 1999 V 2000 V 2001 BY SERVICE TYPE

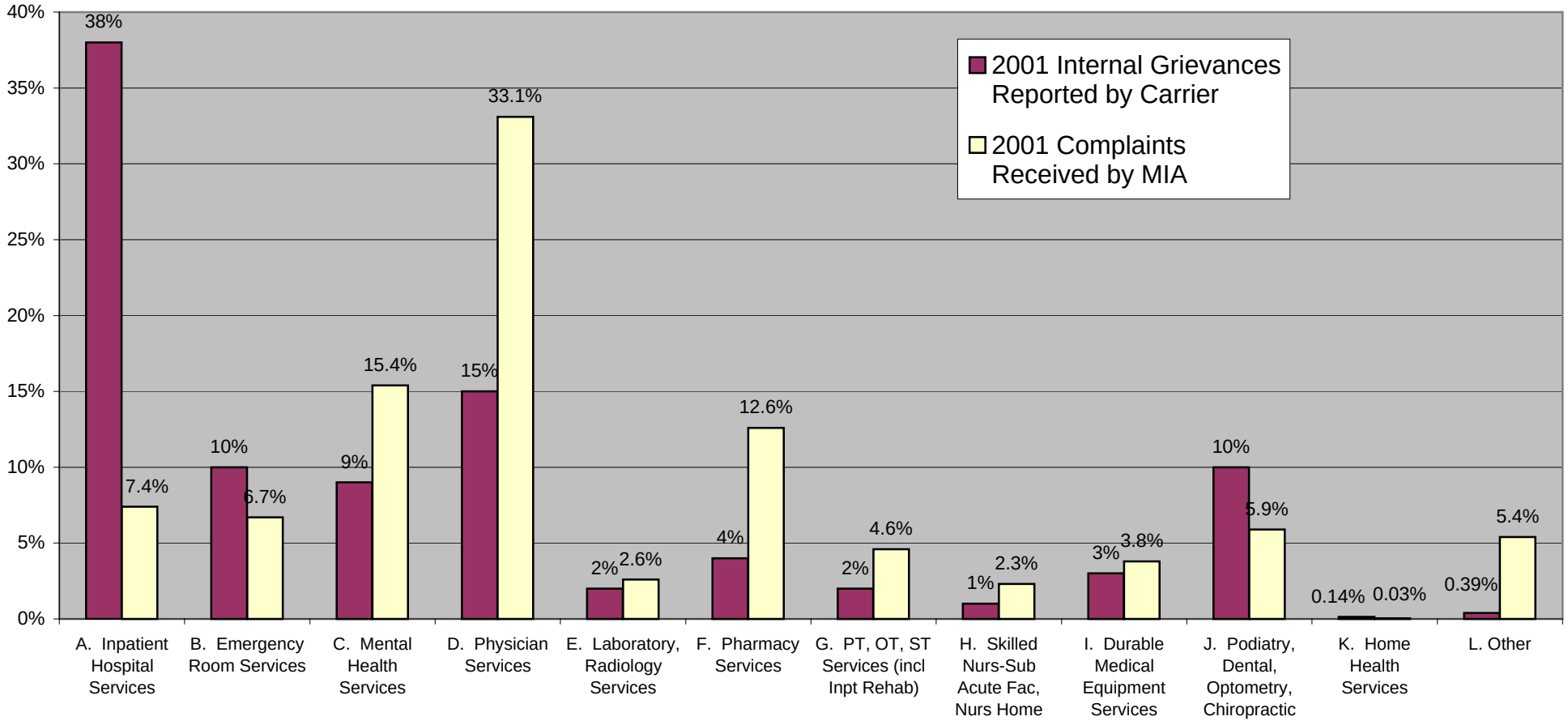


See attached description of what services are included in each procedure.

All carrier data is divided into categories A-L. The MIA's data is more specific in nature. All charts which compare Carrier and MIA data have combined the MIA categories to fit within the carrier's A-L categories. The letters above identify which MIA category corresponds to the carrier code.

A. Inpatient Hospital Services
Denial of Hospital Days
Hospital Length of Stay
B. Emergency Room Services
Emergency Treatment
C. Mental Health Services
Mental Health (Inpatient) Services
Mental Health (Outpatient) Services
Substance Abuse (Inpatient) Services
Substance Abuse (Outpatient) Services
D. Physician Services
Acupuncture
Breast Reduction
Clinical Trial
Experimental
Physician Services
Quality of Care
E. Laboratory, Radiology Services
Lab, Imaging, Testing
F. Pharmacy Services
Pharmacy
G. PT, OT, ST Services (incl inpt rehab)
Inpatient Rehabilitation
Out Patient Rehab
Physical Therapy
PT, OT, Speech Therapy
Rehabilation Services
Speech Therapy
H. Skilled Nurs-Sub Acute Fac, Nurs Home
Assisted Living
Skilled Nursing
I. Durable Medical Equipment
Durable Medical Equipment
J. Podiatry, Dental Optometry, Chiropractic
Dental
K. Home Health Services
Home Health Care
L. Other
Claim Payment
Coordination of Benefits
Denial of Claim
Educational Services
Policy Coverages
Review Carrier's Criteria
Transportation Services

2001 COMPARISON OF CARRIER REPORTED DATA AND MIA DATA



See attached description of what services are included in each procedure.

All carrier data is divided into categories A-L. The MIA's data is more specific in nature. All charts which compare Carrier and MIA data have combined the MIA categories to fit within the carrier's A-L categories. The letters above identify which MIA category corresponds to the carrier code.

A. Inpatient Hospital Services
Denial of Hospital Days
Hospital Length of Stay
B. Emergency Room Services
Emergency Treatment
C. Mental Health Services
Mental Health (Inpatient) Services
Mental Health (Outpatient) Services
Substance Abuse (Inpatient) Services
Substance Abuse (Outpatient) Services
D. Physician Services
Acupuncture
Breast Reduction
Clinical Trial
Experimental
Physician Services
Quality of Care
E. Laboratory, Radiology Services
Lab, Imaging, Testing
F. Pharmacy Services
Pharmacy
G. PT, OT, ST Services (incl inpt rehab)
Inpatient Rehabilitation
Out Patient Rehab
Physical Therapy
PT, OT, Speech Therapy
Rehabilation Services
Speech Therapy
H. Skilled Nurs-Sub Acute Fac, Nurs Home
Assisted Living
Skilled Nursing
I. Durable Medical Equipment
Durable Medical Equipment
J. Podiatry, Dental Optometry, Chiropractic
Dental
K. Home Health Services
Home Health Care
L. Other
Claim Payment
Coordination of Benefits
Denial of Claim
Educational Services
Policy Coverages
Review Carrier's Criteria
Transportation Services

MIA CONSUMER QUESTIONNAIRE 2001

STATISTICAL RESULTS 1/1/01 - 12/31/01	**APPEALS & GRIEVANCES**	
	Quantity	**%**
Questionnaires Sent ***through 12/31/01***	342	**100%**
Response Received ***through 12/31/01***	133	39%

QUESTION TO CONSUMER	**APPEALS & GRIEVANCES**		
	RESPONSE	**#**	**%**
	Total	**133**	**100%**
Did the MIA investigator inform you of the complaint process to your satisfaction?	Yes	111	83%
	No	14	11%
	Unable to Evaluate	4	3%
	No Response	4	3%

QUESTION TO CONSUMER	**APPEALS & GRIEVANCES**		
	RESPONSE	**#**	**%**
	Total	**133**	**100%**
Did the MIA inform you of the final outcome of your complaint to your satisfaction?	Yes	111	83%
	No	16	12%
	Unable to Evaluate	2	2%
	No Response	4	3%

MIA CONSUMER QUESTIONNAIRE 2001

QUESTION TO CONSUMER	APPEALS & GRIEVANCES		
	RESPONSE	#	%
	Total	133	100%
Would you use the MIA's complaint system again if the need arose?	Yes	121	91%
	No	8	6%
	Unable to Evaluate	3	2%
	No Response	1	1%

QUESTION TO CONSUMER	APPEALS & GRIEVANCES		
	RESPONSE	#	%
	Total	133	100%
Was the final outcome of your complaint resolved in your favor?	Yes	91	68%
	No	28	21%
	Unable to Evaluate	12	9%
	No Response	2	2%

QUESTION TO CONSUMER	APPEALS & GRIEVANCES		
	RESPONSE	#	%
	Total	133	100%
If you went through the insurance company's internal grievance procedure prior to filing your complaint with the MIA, were you satisfied with the company's procedure?	Very Satisfied	5	4%
	Satisfied	12	9%
	Not Satisfied	88	66%
	Not Applicable	19	14%
	No Response	9	7%

MIA CONSUMER QUESTIONNAIRE 2001

QUESTION TO CONSUMER	APPEALS & GRIEVANCES		
	RESPONSE	**#**	**%**
	Total	**133**	**100%**
If you went through the insurance company's internal grievance procedure <u>with the assistance of the Attorney General's Health Advocacy Unit ("HAU")</u>, were you satisfied with the *explanation of the process* given to you by the HAU?	Very Satisfied	12	9%
	Satisfied	12	9%
	Not Satisfied	9	7%
	Not Applicable	85	64%
	No Response	15	11%

QUESTION TO CONSUMER	APPEALS & GRIEVANCES		
	RESPONSE	**#**	**%**
	Total	**133**	**100%**
If you went through the insurance company's internal grievance procedure <u>with the assistance of the Attorney General's Health Advocacy Unit ("HAU")</u>, were you satisfied with the *explanation of your grievance's final outcome?*	Yes	19	14%
	No	13	10%
	Not Applicable	84	63%
	No Response	17	13%

QUESTION TO CONSUMER	APPEALS & GRIEVANCES		
	RESPONSE	**#**	**%**
	Total	**133**	**100%**
How satisfied were you with the overall process?	Very Satisfied	78	59%
	Satisfied	23	17%
	Not Satisfied	23	17%
	Cannot Evaluate	3	2%
	No Response	6	5%

MIA CONSUMER QUESTIONNAIRE 2001

CROSS TABULATION - "A"		APPEALS & GRIEVANCE					
How satisfied were you with the overall process?		**TOTAL**	**Very Satisfied**	**Satisfied**	**Not Satisfied**	**Cannot Evaluate**	**No Response**
COMPARED WITH RESPONSE TO:	**TOTAL**	**133**	78	23	23	3	6
Was the final outcome of your complaint resolved in your favor?	**Yes**	91	72	13	3	0	3
	No	28	3	7	16	1	1
	Unable to Evaluate	12	3	3	3	2	1
	No Response	2	0	0	1	0	1

CROSS TABULATION - "A"		APPEALS & GRIEVANCE					
How satisfied were you with the overall process?		**TOTAL**	**Very Satisfied**	**Satisfied**	**Not Satisfied**	**Cannot Evaluate**	**No Response**
COMPARED WITH RESPONSE TO:	**TOTAL**	**100%**	59%	17%	17%	2%	5%
Was the final outcome of your complaint resolved in your favor?	**Yes**	68%	54%	10%	2%	0%	2%
	No	21%	2%	5%	12%	1%	1%
	Unable to Evaluate	9%	2%	2%	2%	2%	1%
	No Response	2%	0%	0%	1%	0%	1%

MIA CONSUMER QUESTIONNAIRE 2001

CROSS TABULATION - "B"		APPEALS & GRIEVANCE					
If you went through the insurance company's internal grievance procedure prior to filing your complaint with the MIA, were you satisfied with the company's procedure?		**TOTAL**	**Very Satisfied**	**Satisfied**	**Not Satisfied**	**Not Applicable**	**No Response**
COMPARED WITH RESPONSE TO:	**TOTAL**	**133**	5	12	88	19	9
Would you use the MIA's complaint system again if the need arose?	**Yes**	121	5	12	78	19	7
	No	8	0	0	7	0	1
	Unable to Evaluate	3	0	0	3	0	0
	No Response	1	0	0	0	0	1

CROSS TABULATION - "B"		APPEALS & GRIEVANCE					
If you went through the insurance company's internal grievance procedure prior to filing your complaint with the MIA, were you satisfied with the company's procedure?		**TOTAL**	**Very Satisfied**	**Satisfied**	**Not Satisfied**	**Not Applicable**	**No Response**
COMPARED WITH RESPONSE TO:	**TOTAL**	100%	4%	9%	66%	14%	7%
Would you use the MIA's complaint system again if the need arose?	**Yes**	91%	4%	9%	59%	14%	5%
	No	6%	0%	0%	5%	0%	1%
	Unable to Evaluate	2%	0%	0%	2%	0%	0%
	No Response	1%	0%	0%	0%	0%	1%

MIA CONSUMER QUESTIONNAIRE 2001

CROSS TABULATION - "C"		APPEALS & GRIEVANCE					
If you went through the insurance company's internal grievance procedure with the assistance of HEAU, were you satisfied with the explanation of the process given to you by HEAU?		**TOTAL**	**Very Satisfied**	**Satisfied**	**Not Satisfied**	**Not Applicable**	**No Response**
COMPARED WITH RESPONSE TO:	**TOTAL**	**133**	12	12	9	85	15
Would you use the MIA's complaint system again if the need arose?	**Yes**	121	12	12	4	81	12
	No	8	0	0	5	1	2
	Unable to Evaluate	3	0	0	0	3	0
	No Response	1	0	0	0	0	1

CROSS TABULATION - "C"		APPEALS & GRIEVANCE					
If you went through the insurance company's internal grievance procedure with the assistance of HEAU, were you satisfied with the explanation of the process given to you by HEAU?		**TOTAL**	**Very Satisfied**	**Satisfied**	**Not Satisfied**	**Not Applicable**	**No Response**
COMPARED WITH RESPONSE TO:	**TOTAL**	**100%**	9%	9%	7%	64%	11%
Would you use the MIA's complaint system again if the need arose?	**Yes**	91%	9%	9%	3%	61%	9%
	No	6%	0%	0%	4%	1%	2%
	Unable to Evaluate	2%	0%	0%	0%	2%	0%
	No Response	1%	0%	0%	0%	0%	2%

How did you learn about the Maryland Insurance Administration ("MIA")?