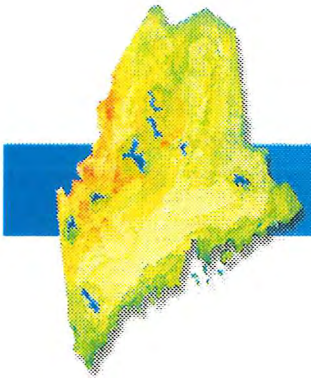

MAINE DEPARTMENT OF
Professional & Financial Regulation

ANNUAL REPORT OF THE CONSUMER HEALTH CARE DIVISION

PREPARED BY THE STAFF OF
THE MAINE BUREAU OF INSURANCE

ANGUS S. KING, JR.
GOVERNOR

S. CATHERINE LONGLEY
COMMISSIONER

ALESSANDRO A. IUPPA
SUPERINTENDENT

Annual Report of the Bureau of Insurance
Consumer Health Care Division
For the Year 1999

1. Background

Public Law Chapter 792, enacted in 1998, authorized the creation of a Consumer Health Care Division (CHCD) within the Bureau of Insurance[1]. The Division is broadly charged with consumer education and assistance with health insurance matters, and with serving as an information resource in the development of policies and programs that protect consumer rights and interests under health care plans.

2. The Division's Activities in 1999

P.L 792 allocated funding for the hiring of a Director, a Staff Attorney and a Nurse. The Director, Alice Knapp, was hired on January 7, 1999. Ms. Knapp had previously served the Bureau of Insurance for nine years as a Staff Attorney specializing in consumer complaint work and health insurance issues. The Division Staff Attorney, Norm Stevens, was hired on February 8, 1999, and the Division Nurse, Kathy Crawford, began work on April 5, 1999.

For its first year of operation, the Division focused its efforts on consumer complaints, outreach and ensuring health plan compliance with the requirements of Bureau of Insurance Rule Chapter 850, Health Plan Accountability.

A. Consumer Complaints. The Division determined that the first step towards improving health insurance consumer satisfaction lay with identifying the causes of consumer dissatisfaction. Recognizing that health insurance complaints received and investigated by the Bureau provide a useful sample of the problems being experienced by some Maine health plan consumers and other participants in Maine's health care system, the Division began meeting weekly to discuss and analyze complaint files. From this work, the Division undertook an initiative to improve the complaint handling process.

In response to these efforts over the past year, Bureau complaint staff began to investigate consumer complaints with the added objective of identifying key issues underlying the complaints. Where problematic process issues are identified, staff bring them to the attention of the health plan with a request that steps be taken to review and revise processes to avoid creating similar problems in the future.

This work builds upon the work begun by the Bureau with the implementation of Bureau Rule Chapter 890, Consumer Complaint Ratios, in 1998[2]. Rule 890 includes

[1] See Appendix A for the duties the Division is charged with under P.L. 792.
[2] See Appendix B for the Bureau's 1999 health insurer complaint ratios for calendar year 1998.

a requirement that the Bureau issue "substantiated complaint"[3] notice letters when closing complaints determined to be substantiated. Complaint notice letters to health plans explain the rationale for the Bureau's conclusion that an investigated complaint has been determined to be substantiated. Complaint investigations may also lead to enforcement referrals to Bureau attorneys. Attached at Appendix C are samplings of thank you letters received by Bureau complaint staff in 1999.

B. Complaint Investigation. The Bureau has broad authority to investigate consumer complaints once authorized by the consumer to access any consumer-related documentation in the possession of a health plan. At the outset of a complaint investigation, Bureau staff routinely request insurer claim files, pertinent policy forms, phone logs, memoranda, medical records and any other documentation related to the subject matter of the complaint. While the documents received by the Bureau in response to its investigative inquiries are protected by law as confidential, the Bureau updates consumers during the course of the investigation to keep the consumer apprised of the issues and the progress of the investigation.

In depth investigation of underlying issues can be time consuming, and the administrative complexities of managed care have made investigating the issues surrounding a complaint more complex at a time when Bureau complaint volumes are steadily increasing. The Bureau received 1,209 complaints in 1999, a 68% increase over the number of health complaints received in 1997, and a 42% increase over the number received in 1998. [4]

The Division Nurse is responsible for complaint file referrals involving medical issues and has handled over fifty complex file referrals during 1999. These

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[3] Rule 890(3)(K) defines a substantiated complaint as:

any written communication by or on behalf of a Maine insurance consumer, expressing grievance or dissatisfaction with an insurer or an entity acting on behalf of an insurer, in which:

1. the Bureau determines, after investigation and opportunity for the subject of the complaint to respond to the complaint and any evidence gathered by the Bureau, that the subject of the complaint:

a. violated any law or rule administered by the Bureau;

b. violated any rate, rating rule, or manual approved by the Bureau;

c. failed to provide a timely response or substantively adequate response to documented consumer inquiries or requests for information;

d. unreasonably delayed settlement of a claim; or

2. the complaint is resolved in a manner favorable to the consumer, and the insurer's failure to have resolved the matter prior to the Bureau's intervention on behalf of the consumer is unreasonable under the circumstances giving rise to the complaint.

[4] See Appendix D.

investigative efforts have identified issues that were referred for enforcement and have resulted in changes to plan processes. The Division Nurse has also met with HMO utilization review staff. These relationships with key plan staff have proven invaluable to our ability to intervene on behalf of consumers facing crisis situations where expedited review of an issue is required.

Bureau complaint staff use each complaint as an opportunity to educate the complainant on their coverage and, to the extent relevant, how managed care works. We have discovered that while many complaints filed with the Bureau are the result of claims administration and other process problems, a good deal of consumer dissatisfaction flows from the failure of health plan members to understand the limitations of their coverage. Plan members tend to believe that if they have health insurance, their coverage should pay for all health conditions that arise and all services that may be recommended or required. Additionally, we have seen consumer confusion regarding coverage arise from plan denials of otherwise covered services on the grounds that a requested service is not medically necessary. Identification of consumer knowledge gaps and issues that contribute to consumer frustration permits the Bureau to develop effective outreach presentations and consumer education materials.

Through its work, the Division has identified the need for an enhanced consumer complaint database to more effectively track and analyze complaint information. The Bureau is developing the parameters for an improved complaint database, and hopes to put a new system on line in the year 2000.

C. Provider Complaints. The Bureau receives a steady volume of provider complaints resulting primarily from provider difficulties with the administrative burdens and complexity of managed care and their difficulties in obtaining payment for services. The Bureau struggled this past year with the development of a policy regarding provider complaints given the already growing volume of consumer complaints requiring staff attention. Ultimately, we concluded provider complaints must be investigated, as providers are an integral part of the health care delivery system. Educating providers on health insurance consumer protection standards such as medical service authorization timelines, appeal rights, prudent layperson emergency services standards, and the like, is a key element of the Bureau's strategy to promote compliance and improve health plan performance. Provider complaints may also serve as an indicator of problems warranting regulatory concern, but the Bureau is concerned with not being used as a collection agency. Accordingly, providers are requested to comprehensively document complaints and to cooperate with the complaint investigation in order to receive regulatory assistance. The Division attorney is also investigating opportunities to promote the development of alternative dispute resolution mechanisms such as those sponsored by various medical organizations in other states.

D. Enforcement. Early in the year, it became clear from the Division's complaint investigation work that there was non-compliance with the requirements of Bureau

Rule Chapter 850, Health Plan Accountability. Accordingly, one of the Division's first initiatives was to identify key standards in Rule 850 for compliance. We believed that ensuring health plan compliance with the standards targeted would improve consumer satisfaction with managed care. A compliance strategy was developed and explained to all Maine licensed HMOs. The plans were invited to attend a compliance seminar held at the University of Southern Maine in Portland in June of 1999.

Following the compliance seminar, the Bureau continued to experience non-compliance with Rule 850, resulting in eight consent agreements through December 1999. The eight consent agreements are attached at Appendix E. While the penalty amounts many be considered nominal,[5] the actions demonstrate the Bureau's commitment to enforcing consumer rights under Maine law, and its belief that enforcement can serve as a deterrent to continued non-compliance.

In addition to its Rule 850 compliance effort, the Division has targeted several provisions of the recently strengthened unfair claims practices section of the Insurance Code for enforcement in the coming year. The Division is particularly interested in targeting noncompliance with the law's requirement that claims not be denied absent a reasonable investigation of the claim. Complaint file review appears to indicate that some health plans may be inappropriately using the Rule 850 mandated appeal and grievance processes to reverse challenged claim denials that would not have been denied initially had the claim been reasonably investigated.

E. Outreach. Early in 1999, the Director contacted interested parties inviting presentation requests. Public interest in the Division led to several invitations to address various groups ranging from consumer and health care provider advocacy organizations to health underwriters and local school superintendents. Appendix F details the Division's 25 public speaking engagements in 1999.

A health insurance tip sheet was developed and posted to the Bureau's homepage (www.maineinsurancereg.org), and refrigerator magnets publicizing the Bureau's homepage and 800 # are being widely distributed. The Division has also taken the first steps toward gathering health plan information for a health plan report card scheduled for publication in the fall of 2000.

F. Utilization Review Entity Licensing. The Division is responsible for administering the Bureau's utilization review entity licensing program. Eleven license applications, renewals and amendments were approved in 1999.

G. Legislation. The Division Director is a member of the Bureau's legislative team on health issues, and provided support and testimony on several health related bills both acted on during the 1999 session and carried over to the year 2000.

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[5] Title 24-A M.R.S.A. § 12-A authorizes the Superintendent to assess civil penalties, "of up to $2000 for each violation in the case of a corporation or other entity other than an individual, unless the applicable law specifies a different civil penalty."

3. The Consumer Health Care Division Advisory Council

The Consumer Health Care Division Advisory Council is made up of the following members:

- Joint Legislative Standing Committee on Banking and Insurance House chair Representative Jane Saxl, Advisory Council Chair
- Joint Legislative Standing Committee on Banking and Insurance Senate chair Lloyd LaFountain
- Department of Professional & Financial Regulation Commissioner S. Catherine Longley
- Christine Zukas-Lessard (Division of Medicaid Policy & Programs, DHS)
- Robert Goldman (Maine Council of Senior Citizens)
- Kathryn Pears (Maine Alzheimers Association)
- Kim Wallace (Alpha One)
- Robert Philbrook (Maine Association of Interdependent Neighborhoods)
- Susan Dore (National Association for the Mentally Ill)
- John Marvin, Maine AFL-CIO

The Council met in December 1998, prior to the Director's appointment, and met in January, February, March, April and November of 1999. Council meeting minutes are attached at Appendix G.

4. Evaluation of the Problems Experienced by Maine Health Plan Consumers

If we assume that consumer complaints received by the Bureau are representative of the problems experienced by Maine health plan members, it is easy to understand that members who experience problems are frustrated by their experience with managed care.

This observation is appropriately qualified by the recognition that thousands of claims are routinely and uneventfully processed by health plans every year, and that many consumers report favorable experience with plan administration of their medical claims. Nor is it irrelevant that managed care has had some success with limiting the rate of health insurance premium increases, which nonetheless continue to rise. There is no question, however, that the administrative complexity of managed care can result in frequent and frustrating problems for both consumers and their providers.

The following are representative of the problems presented to the Bureau during 1999.

- Requested services that do not meet plan criteria are typically denied without further inquiry.
- Denials may be reversed on appeal, but enrollees and their providers become frustrated by the steps required to demonstrate the medical necessity of the services at issue. The appeal process can be overwhelming for individuals and

families experiencing medical crises, or for individuals with limited ability to effectively challenge adverse plan decisionmaking.

- The emphasis by some plans on requiring prior justification for service authorizations in lieu of focussing on utilization and health outcome data to identify inappropriate services can establish an adversarial relationship between plans and their contracted providers. Noteworthy was United Healthcare's announcement that it is returning to its contracted providers the authority to order most services. The company's analysis of its referral and authorization data led to the conclusion that the utilization review requirements in place were not cost effective given the frequency with which the company approved its providers' service authorization requests.
- The frequency with which plans penalize their members for breakdowns in the referral process beyond the control of the member.
- Members and providers continue to be confused by utilization review notices advising that requested services were found by the reviewer to be medically necessary. What often escapes members' attention is the caveat typically attached to these notices stating, for example, that "this is only a review for medical necessity and does not guarantee payment for services." Members may obtain services based on an affirmative utilization review finding only to have their claim for the services denied on the grounds that the service is not a covered benefit under the consumer's health plan. Given the number of problems created by consumer reliance on medical necessity authorizations, it may not be unreasonable to require affirmative medical necessity determinations to confirm whether or not the requested service is covered under the consumer's health plan.

5. Summary & Conclusions

In its first year of operation, the Consumer Health Care Division within the Bureau of Insurance has been effective in its charge of assisting consumers and monitoring health carrier performance. The Bureau handled over 1000 health insurance related complaints, executed eight consent agreements with health insurers for Rule 850 and other Insurance Code violations, and participated in over 25 outreach activities.

Managed care is an administratively complex undertaking that cannot be considered to be functioning universally smoothly in Maine. While consumer and provider unfamiliarity with a relatively new health insurance system may contribute to the problems Bureau complaint investigations identify, we continue to encounter health plan process failures and violations of law. However, the problems brought to our attention present opportunities for significant improvement, and the Bureau is committed to working with health plans, their members, providers, legislators and other stakeholders to effect necessary improvements. The Bureau remains committed to making the Division a success in carrying out its statutory charge.

Appendix A
Duties of the Consumer Health Care Division

Public Law Chapter 792, charged the Consumer Health Care Division with:

A. Providing access to the division through a toll-free number;

B. Providing information to consumers regarding health care plan options and obtaining health care coverage and services…;

C. Assisting enrollees to understand their rights and responsibilities under health care plans;

D. Providing information to consumers on health care plan performance by distributing materials and utilizing existing resources relating to health care plan performance;

E. Providing assistance to enrollees with complaints relating to health care plans, when appropriate…;

F. Collecting and disseminating information regarding health care plans, quality assurance programs and quality improvement and coordinating information with other public entities or agencies involved in the delivery, funding or regulation of health care;

G. Acting as an information resource in the development of policies and programs that protect consumer interests and rights under health care plans by:

> *(1) Analyzing, evaluating and monitoring the development and implementation of federal, state and local laws, regulations, rules and other governmental policies and actions that pertain to the health, safety, welfare and rights of health care consumers; and*
>
> *(2) Identifying practices and policies that may affect access to quality health care, including, but not limited to, practices relating to marketing of health care plans and accessibility of services and resources for under-served areas and vulnerable populations…*

H. Promoting coordination between the division and other organizations that assist consumers, including but not limited to, legal assistance providers serving low-income health care consumers and other health care consumers, health insurance counseling assistance programs, the long-term care ombudsman program…and assistance programs for individuals with disabilities established under federal or state law;

I. Collecting and disseminating information regarding the activities of the division;

J. Submitting an annual report by January 1st of each year to the Commissioner of Professional and Financial Regulation, the Consumer Health Care Division Advisory Council and the joint standing committee of the Legislature having jurisdiction over insurance matters describing the activities carried out by the division in the year for which the report is prepared, analyzing the data available to the division and evaluating the problems experienced by consumers; and

K. Performing other duties as the superintendent may prescribe.

Appendix B
Health Insurer Complaint Ratios
1998 Complaints*

*companies whose premium represents 1% of all health premiums
in Maine in 1998 or which have 5 or more valid complaints

Complaint Index

Group Code	Group Name	1998 Premiums	1998 Complaints	Market Share	Complaint Share	Complaint Index
0505 and 0510	**Individual and Group Health**					
1138	BLUE CROSS & BLUE SHIELD OF ME	522,195,589	36	47.1%	21.1%	0.4
901	CIGNA HEALTH GROUP	172,070,886	27	15.5%	15.8%	1.0
826	NEW YORK LIFE GRP	89,316,698	19	8.1%	11.1%	1.4
595	HARVARD COMMUNITY HEALTH PLAN GRP	47,976,884	11	4.3%	6.4%	1.5
707	UNITED HEALTHCARE INSURANCE GROUP	34,345,083	5	3.1%	2.9%	0.9
416	UNUM	31,117,786	4	2.8%	2.3%	0.8
233	CONSECO GROUP	27,531,223	17	2.5%	9.9%	4.0
2108	DELTA DENTAL PLAN OF MAINE	17,143,961	0	1.5%	0.0%	0.0
332	PRINCIPAL FINANCIAL GROUP	11,795,901	5	1.1%	2.9%	2.7
468	AEGON USA	8,305,158	6	0.7%	3.5%	4.7
19	INTERFINANCIAL INC	7,428,637	9	0.7%	5.3%	7.9
88	ALLMERICA FINANCIAL CORP	4,253,161	5	0.4%	2.9%	7.6
	SubTotals	973,480,967	144	87.8%	84.2%	
Total -	**Individual and Group Health**	**1,108,422,026**	**171**			

Cheryl L. McAllister
98 Sanborn Road
Monmouth, ME 04259
(207) 933-3407

June 30, 1999

Alessandro A. Iuppa, Superintendent
Department of Professional and Financial Regulation
Bureau of Insurance
#34 State House Station
Augusta, ME 04333-0034

RE: Alice E. Knapp, Director, Consumer Health Care Division

Dear Superintendent:

I contacted your agency back in December of 1998 because I was having an insurance problem with Blue Cross/Blue Shield; they refused to pay a November, 1997 hospital bill for no good reason. In March of 1999, my case was assigned to Director Alice Knapp for review.

This insurance problem really bothered me, as I felt I had done everything I was supposed to regarding referrals and so on; BC/BS did not agree and would not even talk reasonably about this with me. Ms. Knapp reviewed all the paperwork I sent her; we talked on the phone; she spoke with BC/BS; sent correspondence to BC/BS; and now my case is settled, with BC/BS finally agreeing to pay my hospital bill.

This letter is to inform you that I was very impressed with Ms. Knapp. She was very professional, very courteous, and always treated me with respect. I felt as though someone was finally listening to what I had to say. She checked into my situation very thoroughly; found some problems with how BC/BS processed my claim; wrote a letter in April, 1999 to BC/BS; everything worked out to my benefit.

Many state offices are overwhelmed with work; Ms. Knapp never made me feel like I was bothering her or that she didn't have time for me. Her letter of April, 1999 to BC/BS was very well written; she obviously knew what she was talking about. She promotes a very good image for your agency, and I thought you should be aware of that fact.

I had to contact your agency approximately thirteen years ago with an insurance problem and everyone was very helpful then also. I just wanted you to know that the people who work in your agency have impressed me, then and now, and Ms. Knapp especially. Thanks to your agency, I now do not have to pay a $1,200.00 bill; I am very grateful for that.

Sincerely,

Cheryl L. McAllister

Cheryl L. McAllister

cc: Alice Knapp ✓

Esquire

MIKE PATERNITI
WRITER AT LARGE

Dear Alice,

Thanks for all of your help on this. We'll keep you posted on what we hear. Again, we appreciate the time you've spent with us.

All best,

Mike & Sara

250 WEST 55TH STREET NEW YORK NY 10019 TEL 207.761.4799

Dear Kathy,

thank you for your help and concern during our insurance appeals process. Your support means a lot to us.

We will keep you posted.

With our appreciation!

Phil, Nancy + Katie
St. Pierre

Governor Angus King
State House Station
Augusta, Maine
04333-0034

COPY

Ann M. Weaver
87 Grandview Avenue
Auburn, ME 04210

207-777-1539

Dear Governor King,

I am writing this letter to let you and the Superintendent of Insurance know of the wonderful service we received from the Bureau of Insurance recently. Without their help (especially Mike McGonigle, Senior Insurance Analyst Maine Bureau of Insurance) I am convinced we would never have reached satisfactory resolution on a Long Term Disability claim.

In December 1993, my husband Michael was disabled by surgery to remove a brain tumor. We filed a claim on our private "own occupation" disability policy. The company refused to pay and we tried for years to deal with them ourselves.

We finally, a year ago, resorted to retaining an attorney and filing a lawsuit. That was dragging on and seemingly going nowhere. Thanks-giving (1998)an uncle of mine (an attorney in Vermont) suggested we get our Bureau of Insurance involved. He stated he'd had good luck in Vermont but warned us that most state agencies were ineffective though it was worth a try.

We filed a complaint and received immediate and unconditional attention from Mike McGonigle. He never let up or lost interest in the case. My husband and I feel that the Bureau's inquiry into this insurance company's practices, was very largely responsible for us having our claim paid.

Donald W Parker
18 Glen Way
So Portland, ME 04106

Oct 26, 1999
So Portland, ME.

Dear Mr. Iuppa,

I would like to inform you of an exceptional employee in your department, his name is Michael Mc Gonigle. Mr. Mc Gonigle recently handled a case for us, against Healthsource of Maine, although your bureau has no jurisdiction over this company, he tried hard on our behalf.

Would you thank him for us for his professionalism and kindness.

Sincerely yours

Elaine Parker
Donald W. Parker

COPY

Monika & Alan Magee
476 Pleasant Point Road
Cushing, Maine 04563-3422
April 27, 1999

Mr. Michael McGonigle
Senior Insurance Analyst
Department of Professional & Financial Regulation
Bureau of Insurance, Life & Health Division
34 State House Station
Augusta, ME 04333

Dear Mr. McGonigle:

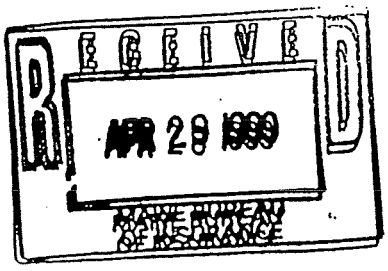
This letter of gratitude is several weeks overdue.

My husband and I want to compliment you on your thoroughness and care in answering our questions regarding our Prudential Chip Policy during our March 26 meeting. We felt that your impartiality and clear understanding of the policy language helped us comprehend exactly what was written in our health insurance contract.

We were encouraged by your willingness to help us fight for our rights should the insurance company try to renege on coverage we understood we had. We left your office with the comforting knowledge that we, and the citizens of Maine, had an intelligent and insightful advocate. Many thanks for your dedication.

Sincerely,

Monika Magee



Don — 8/11/99

Thanks for great work — and really making a difference for this family (attached) — You make us all look good — Best, Angus —

ANGUS S. KING, JR.
GOVERNOR

Don Kline
Bureau of Insurance

6/24/99

To The State of Maine
Bureau of Insurance
Dear Linda Dion –

Thank you Thank you Thank you!
We did it We won!
Thank you so much for all your help. Im sure it wouldnt have happened without you. I am really grateful.
Linda Dion – youre a real sweetheart and youre very very good at your job to. Youre a real credit to the Bureau of Insurance and Im sure you deserve a raise.
I fought the UNUM Co for 6 years but its only with the help of Linda Dion, Congressman Peter DeFazio and Joella Ewing that we won Great job Linda! I'll be in touch again soon.

Thank you again
Sincerely,
Brian Berry

112 Church St.
Bryant Pond, ME 04219
October 9, 1998

Patty T. Woods, Assistant Ins. Analyst
Maine Bureau Of Insurance
Life/Health Division
34 State House Station
Augusta, ME 04333

Dear Patty Woods,

Re: Complaint 199850379
Ellen Hanson
Central United Life Insurance Policy 680509730

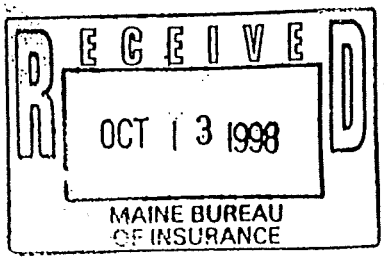
This is a letter to thank you for your work in helping me to get some premium refunds and disability income benefits. It has helped a lot. On Oct. 8th, I received 2 checks ($1047.65 & 125.02) from the insurance company. I believe you have received that information too.

Of course, I wish the insurance company had thought it was a fair and an honorable thing to do to give me benefits for more months that I was unable to work. I believe they had enough evidence for that from the medical information sent them. However, I realize, that since the doctor was not saying "disabled" at that time, they were not required to do it. Without your help, I would not have received any benefits. Anyway, the message of my letter is to express my sincere appreciation for the help you gave me.

Sincerely,

Ellen E. Hanson

Ellen E. Hanson



Fresenius Medical Care
North America
Dialysis and Renal Services

Southern Maine Dialysis Facility

06-08-98

State of Maine
Department of Professional and Financial Regulation
Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Dear Patty,

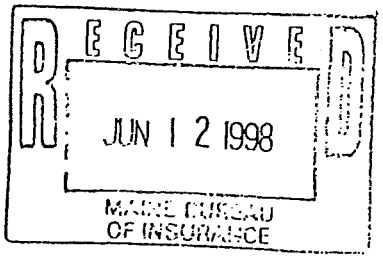
I just wanted to write a quick thank-you note to extend my gratitude to you for all the hard work you offered in assisting me with making sure my client gain rightfull access for a Plan A policy through American Family during their guarentee issue period.

It is nice to know there is an ally in the Bureau of Insurance in advocating for disabled individuals rights to secure adequate insurance coverage. Your efforts not only have helped this individual, but also go a long way in making sure insurance companies uphold their responsibility to provide policies to those in need. Thanks again for your support.

Sincerely yours,

Karen D. Fisher, LMSW

Karen D. Fisher, LMSW



1600 Congress Street Portland, Maine 04102 (207) 774-5985 Fax: (207) 780-0806

October 26, 1

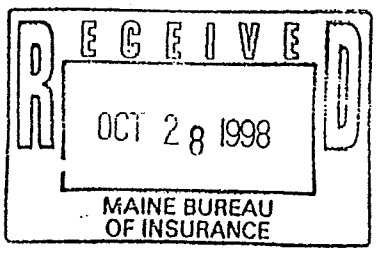
Dear Ms. Woods,

Thank you for your lette to Equitable on my behalf. It u successful and today I received notification that my provider has paid for the additional seven psych therapy visits.

I am extremely grateful you and Nicole Bilodeau for yo assistance with this matter. M complaint is fully resolved and my file can be closed out.

Sincerely,

Suzanne Plai



October 30, 1998

Ms. Patty Woods
Assistant Insurance Analyst
State of Maine
Bureau of Insurance
Augusta, Maine 04333-0034

Dear Ms. Woods:

I did receive a letter from Metropolitan Life Insurance Company this week with a proposal regarding my policy 894311804UL. This proposal is acceptable to me and resolves a long-standing problem concerning this policy. I have signed this proposal and am returning it this week to Metropolitan Life.

I do thank you most sincerely for your help in this matter which I believe would not have been resolved without your assistance.

Sincerely,

James W. Robertson

James W. Robertson
34 Cunningham Road
Freeport, Maine 04032

David Kaufman
54 Waites Landi
Falmouth ME 0

Oct. 20, 1999

Dear Patty –

Well, if that don't beat all!

THANK YOU for your help with Blue Cross/Blue Shield. I received a copy of their letter to you, and 2 days later – over $1400. They would never, NEVER have paid me a nickel without your help – and persistence.

I am very grateful to you, and wish you continued success in your good work on behalf of we citizens!

Again, many thanks.

Sincerely,

David Kaufman

THE DANCING BLANKET
P.O. Box 163 ~~Rt 1 FR 62~~
Thomaston, ME 04861
(207) 354 - 0929

PORTLAND ME 040
PM
FEB
1999

2-3-99

Dear Patty -

Thank you for researching my insurance claim! I'm very pleased that my bill will be paid.

Sincerely
Cynthia McGuire

Patty Woods
Bureau of Insurance
34 State House Sta
Augusta, ME

RECEIVED
FEB - 8 1999
MAINE BUREAU OF INSURANCE

photo: handwoven cotton jacket

#1999506608

COVER SHEET FAX

To: Michael Roberts, Bureau of Insurance
Fax #: 207-624-8599
Subject: payment - Bankers Life
Date: 12/13/99
Pages: 3

COMMENTS:

Thank you for so successfully handling my problem with payment from Bankers Life. Along with this cover sheet are copies of checks totalling full payment of $375.00

December 5, 1999

Mr. Al Iuppa
Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Mr. Iuppa:

This comes as a huge thank you to your office for a request I made to intervene on my behalf to settle a dispute with our insurance company.

With the help of your office and in particular one of your employee's, Don Kline, the problem was resolved to my benefit, which I might add, should have been done without question in the first place!

But, Don accepted the challenge with extreme care and understanding, keeping me informed and working to resolve the claim to my benefit and satisfaction.

His demeanor and caring certainly restored my faith in bureaucratic performance and I have only the highest praise for Don and all he did to help me, plus keeping me apprised of the situation.

You are fortunate to have such a valuable employee, and, I hope you realize it.

Thank you for a job well done Don, I really, really appreciate everything you did on my behalf.

Sincerely,

Francine H. Riha

Francine H. Riha
/fhr

cc: Don Kline

PO Box 597
Guilford, ME 04443
April 8, 1999

Angus S. King, Jr. Governor
State of Maine
1 State House Station
Augusta, ME 04333-0001

Dear Governor King:

The Maine Bureau of Insurance provides an excellent service to the citizens of Maine. Recently, it was necessary for me to file a complaint on an insurance company.

Mr. Chad Whelsky handled the problem for me. My letter was answered the day it was received, and telephone conversations kept me up to date on the progress being made.

The insurance company took several weeks to act on Mr. Whelsky's requests. However, the matter was resolved yesterday to my satisfaction. Without the help of the Maine Bureau of Insurance, especially Mr. Whelsky, I am sure the matter would have continued for another two years.

As complaints about State agencies surly reach your desk, I wanted to send this letter stating how much I appreciated the excellent service I received from the Maine Bureau of Insurance.

Sincerely,
Catherine P. Richard
Catherine P. Richard

5/20 Chad — Congratulations and thanks — Angus —

Fax

LAW OFFICES OF JENNIFER F. KRECKE

34 River Street
P.O. Drawer L
Rumford, Maine 04276
(207) 364-4593
Fax (207) 369-9421

Organization:	**Maine Bureau of Insurance**
	Attn: Chad Whelsky
Fax:	(207)624-8599
From:	Tammy J. Ferland
Date:	July 22, 1999
Subject:	Decision Letter from Central Maine Partners
Page (Including cover sheet):	2

Comments: Chad, thank you so much for all your help and support in this matter. I am very happy about the outcome! There was no cc to the Bureau of Insurance, so I wanted to forward this to you. Have a great day!!!

COPY

Northeast Cardiology Associates
A member of Northeast Heart Institute, LLC

ONE EVERGREEN WOODS
700 MT. HOPE AVENUE
BANGOR, MAINE 04401

207-947-4940

June 10, 1999

Chad Welski
Bureau of Insurance
Consumer Division
34 State House Station
Augusta, Me 04333

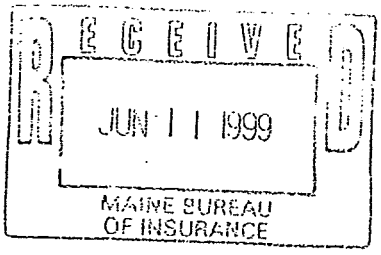
Re: Harold Hamm

Dear Chad:

I wanted to thank you for your help with this problem account. We have finally received payment for Mr. Hamm's 1997 date of service.

Sincerely,

Krista Dauphinee
Northeast Cardiology Billing Department



Fred F. Carroll, Sr.

2 DX Drive ~ RR 2 Box 3480 ~ Belfast, Maine 04915-9651
Home Phone 207-338-9816 ~ Email kd1hh@acadia.net

June 8, '99

Hi Chad:

I had a Ham Radio Pal in Oklahoma City call the Post Office there and the Postage Meter that stamped the enclosed envelope belongs to GLOBE LIFE

Funny they held the check from 5/20/99 To 6/04/99 until you called them! They should be fired!

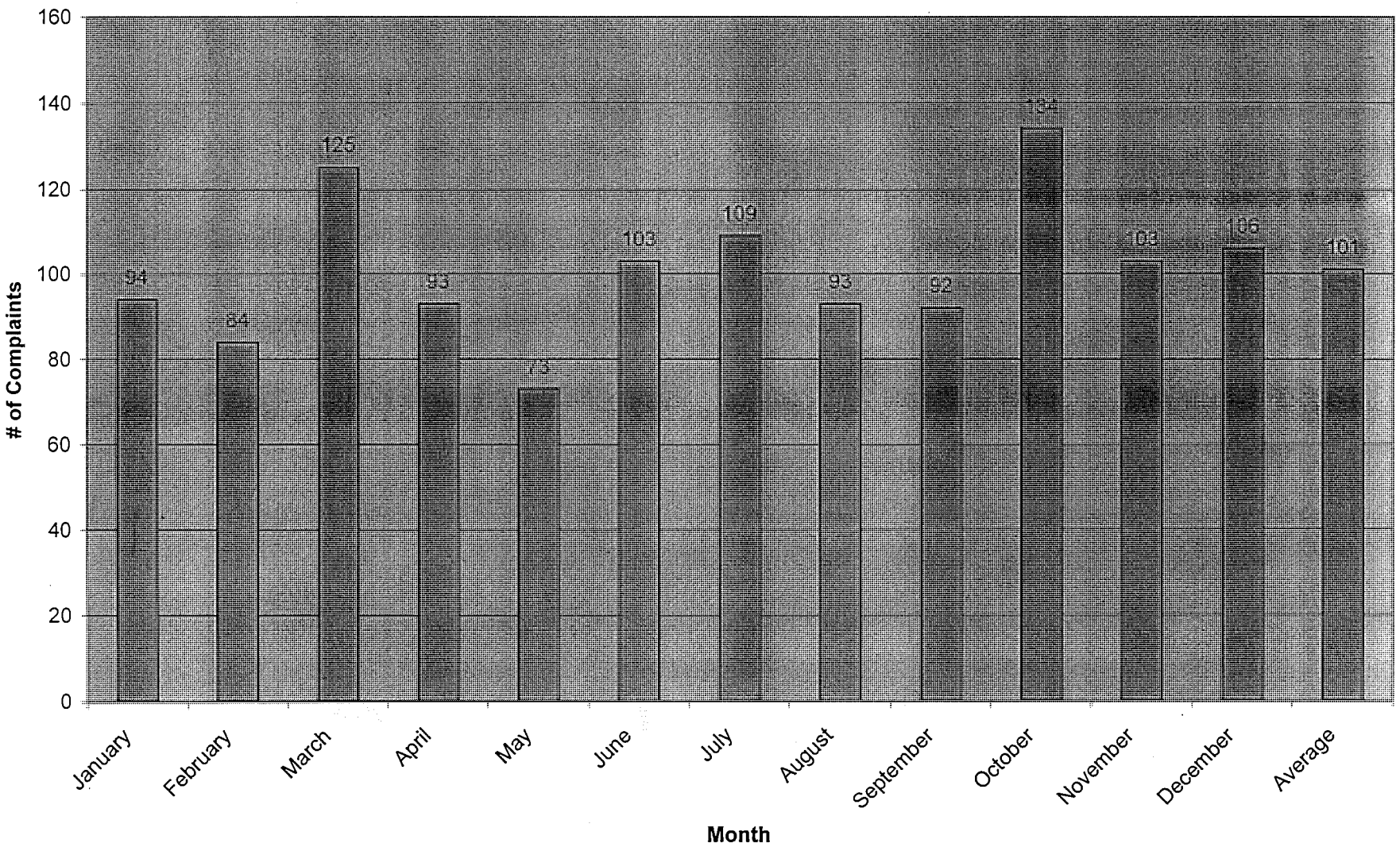
Anyway, thanks to your efforts my 3month plus Odyssey is ended and me and GLOBE are settled.

I sure appreciate all your help!

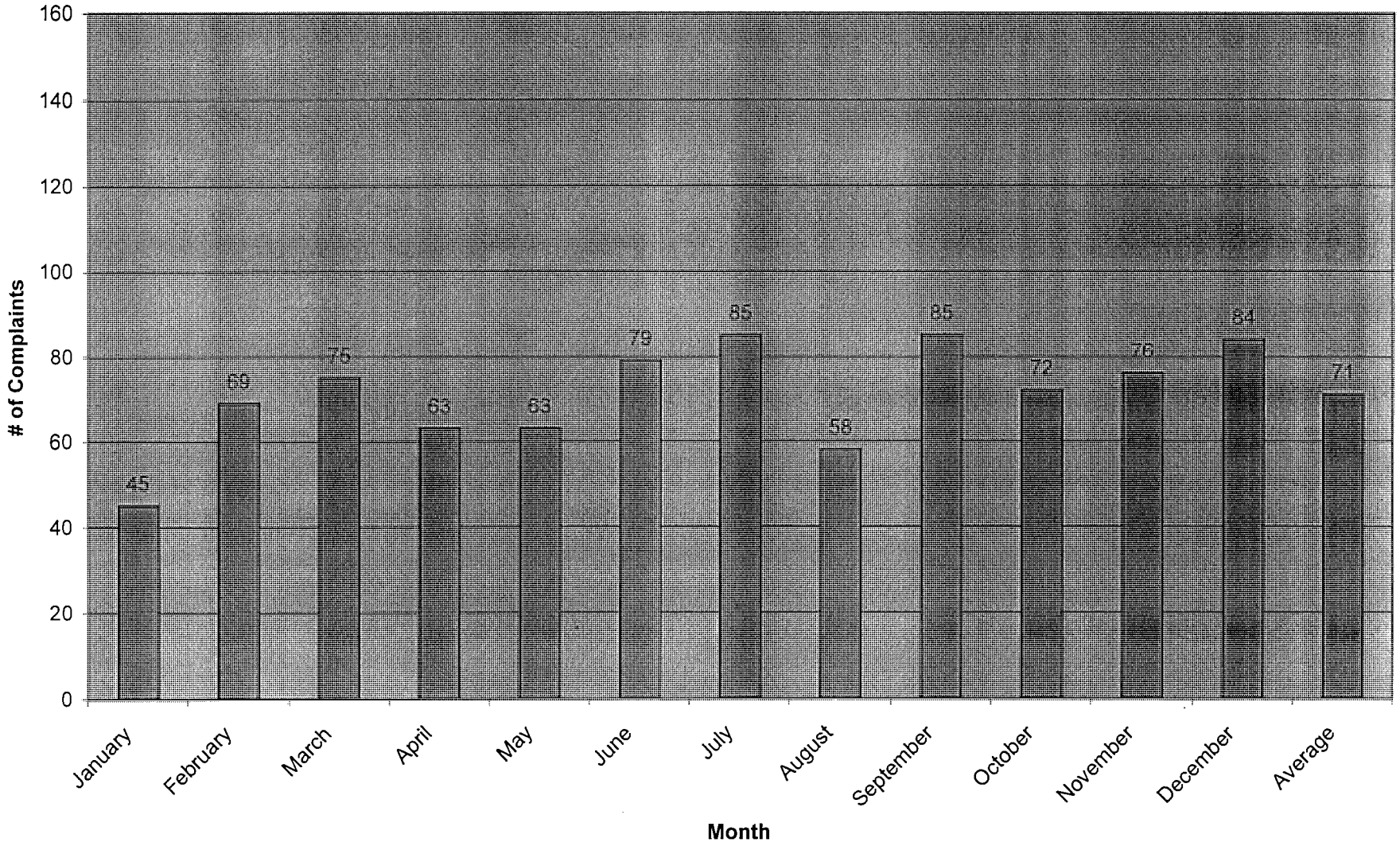
Thanks Again

Fred F. Carroll

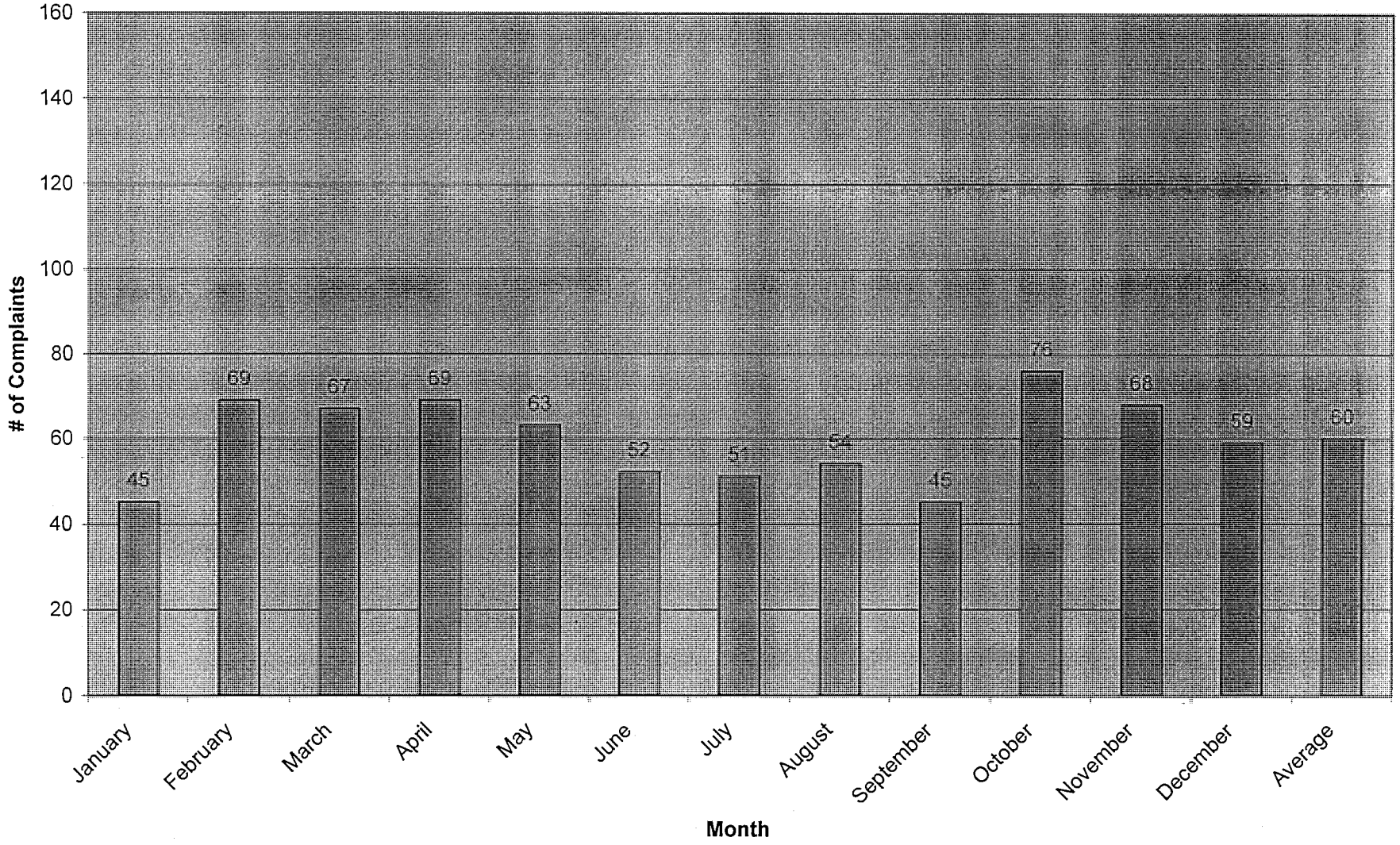
Life and Health Complaints Logged 1999



Life and Health Complaints Logged 1998



1997 Life and Health Complaints Logged



STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ANGUS S. KING, JR.
GOVERNOR

ALESSANDRO A. IUPPA
SUPERINTENDENT

IN RE: HEALTHSOURCE MAINE, INC.) **CONSENT AGREEMENT**
) **BUREAU OF INSURANCE**
) **DOC NO. MCINS 99 - 28**

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among Healthsource Maine, Inc. (hereafter "Healthsource") and the Superintendent of the Maine Bureau of Insurance (hereafter also "the Superintendent"). Its purpose is to resolve, without resort to an adjudicatory proceeding, violations of Bureau of Insurance Rule Chapter 850 as set forth below.

FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations.

2. Healthsource Maine, Inc has been a Maine licensed HMO, License # HMD 4, since 1987.

3. On April 9, 1999 Consumer wrote a letter of appeal to Healthsource, stating:

> *I am writing to you to appeal a decision to take back money that was paid to cover Intrauterine Insemination. I have recently received a call from [Provider] regarding this issue. I believe from my conversation with [Provider] that you are in the process of reversing your payments.*
>
> *Let me begin from the beginning. In March, 1998, I called Healthsource to inquire about Intrauterine Insemination whether my insurance covered this procedure or not. The answer I received was yes but I would have a small percentage I would pay. I thought great, I can afford this. So I call [Provider]*
>
> *about starting the process and received the same answer from them that this is a covered procedure. I had my first insemination in April, 1998, when I received the "explanation of benefits/coverage" from Healthsource I had a remainder of $25.00 + to pay. So when the first insemination didn't take I felt comfortable that*

I could continue to pay the same amount to keep trying. So I did, until September, 1998.

During the five months (4/8, 6/1, 7/7/, 8/5, 9/2) I had the insemination done all I had to pay was under $30,00. I was never informed during this time that part of this wasn't covered. Each time a bill was submitted, the payment to [provider] was inconsistent, varying from 20+ to 30+ dollars.

I am informed by [Provider] that there was an incorrect code put in (99070), which is a generic code. I did not make this error nor was I informed during the last 13 months, till now.

My appeal to this is that if I had been informed on the initial call to Healthsource or even after I received the first or second explanation of benefit that part of the insemination process was not a covered benefit, I would not have continued to have this done for I couldn't have afforded it. I do not feel I should have to pay the $900.00 to $1000.00 amount that was not covered for I wouldn't have done and it was not my error it was coded incorrectly.

I am truly upset by this a) because it didn't work; and b) I am not financially able to afford this bill, again if I had known I wouldn't of had it done, because I wouldn't have been able to pay for it.

4. On May 7, 1999 Healthsource sent Consumer an adverse appeal determination letter which stated in relevant part:

Thank you for your recent letter of appeal requesting Healthsource Maine approve and pay for Intrauterine Insemination on 4/8/98, 6/1/98, 7/7/98, 8/5/98, and 9/2/98, at [Participating Provider].

For future reference, Medically Necessary and Infertility information was outlined in your Group subscriber Agreement on pages 13, 17, and 21 as follows:

Page 13.) Determinations for Medically Necessary services are based upon regional and national standards of care and clinical criteria established by Participating Providers of Healthsource. Primary Care Physicians and other health care professionals shall provide Healthsource with information necessary to determine coverage of health care services. The Medical Director will, as necessary, consult with participating specialists to review a Member's care to determine if the requested services are Medically Necessary and appropriate. A decision will be made within 2 business days of receiving all necessary information

Page 17.) Infertility Services: Coverage is provided for procedures, treatment and services related to the Treatment of infertility. Benefits provided for methods of impregnation are provided when Authorized or provided by your Primary Care Physician. These include only invitro fertilizaiton, Artificial insemination and gamete intrafallopian (GIFT). Coverage is limited to Members who have undergone extensive screening and counseling and have been selected for Invitro fertilization, artificial insemination, and GIFT treatment for any one of the following Reasons:

absent or irreparably damaged fallopian tubes or severe tubal disease; low male sperm count; or idiopathic fertility.

Surrogate donors, male or female, are not covered.

P. 21. Infertility treatments not specifically addressed in Section 4.H. (5) are not covered."

5. Rule 850(9)(C)(1)(b)(ii) requires that if a decision in a first level appeal is adverse to the covered person, the written decision shall contain:

> *A statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.*

6. Consumer filed a formal complaint, complaint # 1999505507, on May 18, 1999, concerning the same issues that she raised in her first appeal letter, set forth in paragraph 3, above.

7. On that same date, May 18, 1999, Consumer also filed a second level appeal with Healthsource, again raising the same issues that she raised in her first appeal letter, set forth in paragraph 3, above.

8. On June 25, 1999, Healthsource wrote to Consumer granting her second level appeal. The June 25, 1999 approval letter states in part:

> *The Management Grievance Committee reviewed your case and determined that this request will be approved as an exception. This decision was based on the fact you were unaware that this procedure was not covered prior to services rendered. You were unaware until April, 1999 that these services are not covered under the State of Maine plan because the claims were processed incorrectly at Healthsource Maine. The claims will be re-processed and paid at 80% of the usual and customary charges. These services will be applied to the $20,000 lifetime maximum for infertility services.*

CONCLUSIONS

9. As described in paragraph 3 and 4 above, Healthsource's first level adverse appeal determination letter violated Rule 850(9)(C)(1)(b) by failing to include a "*statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.*" In particular:

- *The first level adverse appeal determination notice failed to acknowledge or address Consumer's assertion that her Explanation of Benefits statements led her to a reasonable belief that her out of pocket expenses would be only $25 or $30 dollars per treatment.*

- *The first level adverse appeal determination notice failed to acknowledge or address Consumer's argument that the billing code error was not her fault and therefor she should not be held responsible.*
- *The first level adverse appeal determination notice failed to acknowledge or address Consumer's argument that she would not have been able or willing to undertake additional treatment had she been made aware early on of the cost of those treatments.*

COVENANTS

10. A formal hearing in this matter is waived and no appeal will be made.

11. At the time of executing this Agreement, Healthsource will pay to the Maine Bureau of Insurance a civil penalty in the amount of two thousand dollars ($2,000), payable to the Treasurer of the State of Maine.

12. In consideration of Healthsource's execution of and compliance with the terms of this Consent Agreement, the Superintendent agrees to forgo pursuing any disciplinary measures or other civil sanction for the actions described above other than those agreed to in this Consent Agreement.

MISCELLANEOUS

13. This Consent Agreement may only be modified by the written consent of the parties.

14. It is understood by the parties to this Agreement that nothing herein shall affect any rights or interests that any person not a party to this Agreement may possess.

15. Healthsource acknowledges that this Consent Agreement is a public record within the meaning of 1 M.R.S.A. § 402 and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408.

16. Healthsource has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this Agreement.

FOR HEALTHSOURCE MAINE, INC.

Dated: Nov. 24, 1999

By: A. M White
Signature

For: A M WHITE
Typed Name

GENERAL MANAGER
Typed Title

this 24 day of Nov, 1999.

Barbara J Cremo-Graham
Notary Public
My Commission expires Sept 26, 2002

FOR THE BUREAU OF INSURANCE

Dated: 12/2, 1999

Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, SS.

Subscribed and sworn to before me
this _____ day of _____, 1999.

_____
Notary Public/Attorney-at-Law

FOR THE MAINE ATTORNEY GENERAL

Dated: Nov. 30, 1999

Judith Shaw Chamberlain
Assistant Attorney General

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ANGUS S. KING, JR.
GOVERNOR

ALESSANDRO A. IUPPA
SUPERINTENDENT

IN RE: THE UNITED STATES LIFE INSURANCE COMPANY) **CONSENT AGREEMENT**) **BUREAU OF INSURANCE**) **DOC NO. MCINS 99 - 25**

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among The United States Life Insurance Company (hereafter "US Life") and the Superintendent of the Maine Bureau of Insurance (hereafter also "the Superintendent"). Its purpose is to resolve, without resort to an adjudicatory proceeding, violations of Bureau of Insurance Rule Chapter 850 as set forth below.

FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations.

2. US Life has been a licensed life and health insurance company, License # LHF654, since 1954.

3. Consumer was hired by his employer on August 25, 1997. One year later, on August 27, 1998, he enrolled in the US Life group insurance plan.

4. Under the insurance plan Consumer was required to be a full time employee for 3 months before becoming eligible to enroll with the Dental Plan. At the end of 3 months of employment, employees have a 31 day open enrollment period. Employees who enroll after the 31 day open enrollment period are classified as "late entrants."

5. On November 26, 1997, Consumer had been employed for three months and was eligible to enroll with the Dental Plan. Consumer did not enroll in the plan until August 27, 1998, nine months later. Consumer was therefor classified as a "late entrant" under the policy.

6. Consumer's policy provides that no benefits for basic dental services will be paid for a "late entrant" until the enrollee has been insured for six months.

LOCATED AT: 124 NORTHERN AVE., GARDINER, MAINE 04345
PHONE: (207)) 624-8475 TDD (207) 624-8563 CUSTOMER COMPLAINT 1-800-300-5000 FAX: (207) 624-8599

decision, the procedures and time frames governing a second level grievance review, and the rights specified in subsection D(3)(c).

11. On May 5, 1999, Consumer filed a formal complaint with the Maine Bureau of Insurance, Complaint No. 1999505492. The complaint stated, in relevant part:

> *After 1 yr. of employment with [employer] I enrolled in their dental plan (group). I was not informed that because I had waited 1 yr. I was a "late entrant" and must wait 6 months for basic care and 1 yr. for major surgery. After I had my fillings and the dentist filed the claim I received an "explanation of benefits" that stated the service would not be covered...I appealed the decision to the U.S. Life Ins. Company which is when I received a letter from [the company] telling me the "late entrant" explanation can be found in the "benefit booklet". The reason I appealed their decision was because I never received a "benefit booklet" or any info. on my insurance telling me I had a "waiting period'. I almost believe [the company] never read my letter of appeal or she would have known this.*

12. On June 24, 1999, US Life wrote to the Bureau of Insurance advising that it is the responsibility of the employer's plan administrator to distribute benefit booklets. The June 24th letter stated in part:

> *When the group becomes effective with United States Life Policy, we issue to the Plan's administrator a group insurance plan administrator's guide along with ID cards, certificates, claim forms and benefit booklets for the original employees and new employees. The Administrator Guide explains when and how to order supplies. It is the Administrator's responsibility to order supplies when needed. In the last six months we did not receive a request from the administrator to sent more supplies. therefor, if Mr. Doucette did not receive a benefit booklet he should contact his administrator.*

CONCLUSIONS OF LAW

13. As described in paragraphs 9 and 10 above, US Life's April 16, 1999 adverse appeal notice violated Rule 850(9)(C)(1)(b)(ii) by failing to include a statement of the reviewers' understanding of the covered person's grievance and all pertinent facts. This Rule requires insurance carriers to acknowledge and address the specific arguments and fact set forth in the Consumer's appeal. In this instance the appeal decision should have acknowledged and addressed Consumer's statement that he was not informed about the "late entrant" provisions in the plan, which was the core issue on appeal. Consumer's appeal did not dispute the existence of the terms of coverage relied upon by US Life in its adverse appeal determination.

14. As described in paragraph 10 above, US Life's April 16, 1999 adverse appeal notice violated Rule 850(9)(C)(1)(b)(v) by failing to include a notice of the covered person's

For United States Life Insurance Company

Dated: Nov. 10, 1999

By: R E Stanko
Signature

For: Richard E. Stanko
Typed Name

Administrative Officer and Assistant Secretary
Typed Title

this 10th day of November 1999.

Mary Kay O'Neill
Notary Public

OFFICIAL SEAL
MARY KAY O'NEILL
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/25/00

For the Bureau of Insurance

Dated: 11/12, 1999

Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, SS.

Subscribed and sworn to before me
this _____ day of _____, 1999.

_____
Notary Public/Attorney-at-Law

For the Maine Attorney General

Dated: Nov. 12, 1999

Judith Shaw Chamberlain
Assistant Attorney General

AMERICAN GENERAL ASSURANCE COMPANY

062057

VEN01 DATE: NOV 04, 1999
TY0505
JN

CHECK NO.: 062057

AMOUNT: *****6,000.00

CONSUMER COMPLAINT SETTLEMENT

9-4001 DETACH BEFORE DEPOSITING B300009-1668-0798

1000 Woodfield Road, Suite 300
Schaumburg, Illinois 60173-4793

AMERICAN GENERAL ASSURANCE COMPANY

70-2328
719

No. 062057

NOV 04, 1999

1

BANK OF AMERICA
Northbrook, IL
Controlled Disbursement Account

AMOUNT : *****6,000.00

Pay To The Order Of

PLEASE DEPOSIT WITHIN 90 DAYS

TREASURER STATE OF MAINE

⑈000006205 7⑈ ⑆071923284⑆ 87653⑈6251 2⑈

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ANGUS S. KING, JR.
GOVERNOR

ALESSANDRO A. IUPPA
SUPERINTENDENT

IN RE: HEALTHSOURCE MAINE, INC.) **CONSENT AGREEMENT**
) **BUREAU OF INSURANCE**
) **DOC NO. MCINS 99 - 18**

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among Healthsource Maine, Inc. (hereafter "Healthsource") and the Maine Superintendent of Insurance (hereafter also "the Superintendent"). Its purpose is to resolve, without resort to an adjudicatory proceeding, violations of Bureau of Insurance Rule Chapter 850 as set forth below.

FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations.

2. Healthsource Maine, Inc. has been a Maine licensed HMO, License # HMD 4, since 1987.

3. Consumer filed a formal complaint, complaint # 1999505205, with the Bureau of Insurance on April 6, 1999, challenging Healthsource's denial of coverage for additional chiropractic visits. Consumer's complaint was forwarded by the Bureau to Healthsource for a documented response on April 9, 1999.

4. On March 30, 1999, Healthsource sent Consumer a Denial of Services letter, stating in relevant part:

> *"We have received a referral for [Consumer] from [Provider]. The Medical Director reviewed the information sent in by your doctor and has not approved coverage because: Add'l Chiropractic Visits Denied. Progress Notes Denote Functional Abilities To Complete Daily Activities."*
>
> *"...If you have any questions or wish to receive a copy of the clinical rationale used to make this determination, please call our Member Services Department."*

5. On April 6, 1999, Consumer's provider appealed Healthsource's adverse determination.

6. On April 12, 1999, Healthsource wrote to Consumer's provider, acknowledging receipt of the provider's appeal, and copying Consumer. The April 12th letter stated in relevant part:

"This review will be conducted within 20 days, unless there is an unforeseen delay due to complications in collecting necessary information. Should this occur, Healthsource/CIGNA will notify you in writing of the need for an extended investigation period."

7. Rule 850(8)(G)(1)(c) provides (emphasis added):

"The health carrier or the carrier's designated URE shall notify in writing both the covered person and the attending or ordering provider of the decision within 20 working days following the request for an appeal."

8. On May 24, 1999, 29 working days after the date Healthsource acknowledged receipt of Consumer's April 6, 1999 appeal, Healthsource sent Consumer an adverse determination notice denying her appeal. Healthsource has advised the Bureau that the 20 day time limit was not met because additional time was required to conduct an external review.

9. Rule 850(8)(G)(1)(b) requires that appeals "*shall be evaluated by an appropriate clinical peer or peers.*" Healthsource has identified its external clinical peer reviewer as the clinical peer who evaluated the appeal.

10. Rule 850(8)(G)(1)(c)(i) provides that an adverse decision notice must contain:

(i) *The names, titles and qualifying credentials of the person or persons evaluating the appeal."*

11. Although Healthsource's May 24, 1999 adverse determination notice contains the names and titles of the Appeals Committee members, it does not contain the name of the reviewing licensed chiropractor designated by Healthsource as the reviewing clinical peer.

12. Healthsource's May 24, 1999 adverse determination notice states in relevant part:

"Thank you for your letter of appeal on behalf of [Consumer], requesting Healthsource Maine approve and pay for additional chiropractic visits. The Appeal Committee has reviewed your case, including the [4/6/99] letter from you and office notes dated 2/24/99 and 3/19/99 and determined that this request will be denied. This decision was based on the recommendation of an independent external review, which was conducted by a Licensed Chiropractor in the State of Maine. Additional visits are not medically necessary, specifically numbers 1 and 6, as outlined below. [Consumer] should continue with an independent exercise program to maintain progress, as this would be a medically appropriate treatment plan. Additional chiropractic visits may be considered medically necessary if a re-injury or exacerbation occurs."

"For future reference, Medically Necessary information is outlined in [Consumer's] Subscriber Agreement on page 9 as follows:

1. *Consistent with the symptoms or diagnosis and treatment of the member's condition.....*
6. *The most appropriate supply, level of care or service which can be safely and effectively provided to the member."*

13. On May 28, 1999 Healthsource sent the Bureau of Insurance a written response to Consumer's formal complaint. Healthsource's response states, in relevant part:

> *"[Provider] received notification of this denial of services when the referral for additional visits was denied on March 30, 1999. The member, primary care physician and specialist are notified of all referral determinations. When Healthsource Maine received [provider's] appeal letter, a hearing was scheduled. [Consumer's] case was reviewed by [Associate Medical Director], at the appeal. He requested a peer review from a licensed chiropractor in the State of Maine. The denial for continued chiropractic care for this injury was upheld in the appeals process after a peer review was conducted."*

14. On June 7, 1999, Consumer's provider wrote to Healthsource requesting additional information. That letter stated in part:

> *"<u>This letter is not the appeal</u>, it is simply a request for further information so that we can draft an effective appeal... We obviously disagree with that decision and will need a copy of the signed independent external review conducted by a licensed chiropractor... in order to complete our appeal. We also need the name and [curriculum] vitae of the reviewing licensed chiropractor. Also, we need to know the name of the source, reference or guide that is used to complete the review. Lastly, would you please send us a copy of the clinical rational[e] used to make the initial denial determination."*

15. On June 9, 1999, Consumer wrote a letter to the Bureau explaining her dissatisfaction with the review of her claim.

16. On June 30, 1999, the Bureau wrote to Healthsource advising that Healthsource's May 24, 1999 adverse determination notice failed to comply with Rule 850. The Bureau's letter also directed Healthsource to send Consumer and her provider a new adverse determination letter containing all of the requirements of Rule 850(8)(G)(1)(c)(i, iii, iv, v).

- Rule 850(8)(G)(1)(c)(i), set forth at paragraph 10 above, requires the names, titles and credentials of the person evaluating the appeal.
- Rule 850(8)(G)(1)(c)(iii), set forth at paragraph 20 below, requires clinical rational in sufficient detail for the covered person to respond.
- Rule 850(8)(G)(1)(c)(iv), set forth at paragraph 23 below, requires a reference to the evidence and the clinical review criteria the decision is based upon.
- Rule 850(8)(G)(1)(c)(v), set forth at paragraph 25 below, requires a description of the process for filing a second level grievance.

17. On July 1, 1999, Healthsource sent Consumer's provider the external reviewer's curriculum vitae, and copies of the notes the external reviewer submitted with his review. Healthsource's letter advised Consumer's provider that:

> *"Letters of Clinical Rationale for the denied services are provided by the Health Services Department at Healthsource. These letters of clinical rationale will be forwarded to you under separate cover. I enclosed a copy [of] the Group Subscriber Agreement for your reference, Please refer to section 4.A (7) page 14 that refers to the covered services for chiropractic care."*

18. On July 15, 1999, in response to the Bureau's June 30th request, Healthsource sent Consumer and her provider a revised adverse appeal determination letter. Except for the addition of the 2nd level appeal rights required by Rule 850(8)(G)(1)(c)(v), this letter essentially restated the language of the May 24th adverse determination notice cited at paragraph 12.

19. On July 15, 1999, Healthsource also responded to the Bureau's June 30, 1999 letter, in which the Bureau advised that Rule 850 requires adverse utilization review notices to include the names, titles, and credentials of the appeal reviewer. Healthsource stated:

> *"Rule 850 requires health plans to list the members of the Appeal/Grievance Committees with their credentials. [Healthsource's external peer reviewer] is not a member of our committee. His external review was requested to provide a peer review to determine if the care was appropriate and/or medically necessary. It is Healthsource's understanding that [external peer reviewer's] name and credential's are not required in this letter, but that we are required to release them to the member, or member's representative if asked."*

20. The Bureau's June 30, 1999 letter directed Healthsource to provide Consumer with an adverse determination notice which complied with Rule 850(8)(G)(1)(c)(iii). Rule 850(8)(G)(1)(c)(iii) requires adverse determination notices to contain:

> *(iii) The reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position.*

21. Healthsource's July 15, 1999 letter responded to the requirements of Rule 850(8)(G)(1)(iii), stating in part:

> *"Additional chiropractic visits were denied Consumer because they were not medically necessary. The determination letter directly quotes the criteria for medical necessity from the Group Subscriber Agreement (1-6). This quotation provides [Consumer's provider] and [Consumer] with a copy of the criteria and a reference point for its source. The paragraph preceding the quotation provides the reasons why the care was not medically necessary, specifically pointing to 1 and 6. The appropriate treatment plan recommended as a result of this review is a home treatment plan. Additionally*

[Consumer] is advised that if there is re-injury or an exacerbation of her condition, then continued chiropractic care may then be deemed medically necessary (consistent with the symptoms or diagnosis and treatment)."

22. Healthsource's May 24, 1999 adverse determination letter advised only that the requested services are not medically necessary because they are not:

"*(1)Consistent with the symptoms or diagnosis and treatment of the member's condition,*" and are not
(6) The most appropriate supply, level of care or service which can be safely and effectively provided to the Member."

23. Bureau of Insurance Bulletin 265, dated July 17, 1997, specifically addresses the Bureau's interpretation of statutory requirements that adverse utilization review determination notices include the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position. Bulletin 265 provides (emphasis added):

*"It has come to the Bureau's attention that adverse utilization review determinations sometimes fail to communicate any meaningful explanation for the reviewer's conclusion that a requested service is not medically necessary. Examples would include denials on the grounds that the requested service "**is not medically necessary**" or "**does not reflect the most efficacious or effective care possible for this diagnosis.**"*

...Conclusory statements of the sort described above simply repeat the decision rather that "stating the basis for the decision" as required by law. Consistent with the requirements of law, an adverse utilization review determination must explain the reason(s) underlying the conclusion that a requested service is not medically necessary."

24. Rule 850(8)(G)(1)(c)(iv) provides that adverse determination notices must contain:

"(iv) *A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision shall include instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to the covered person.*"

25. Healthsource's May 24, 1999 adverse determination notice made no reference to clinical review criteria, or to Consumer's right to request request copies of any clinical review criteria or documentation relied upon by Healthsource in arriving at its decision.

26. Rule 850(8)(G)(1)(c)(v) provides that adverse determination notices must contain:

"A description of the process for submitting a written request for second level grievance review pursuant to section 9(D), the procedures and time frames governing a second level grievance review, and the rights specified in section 9(D)(3)(c)."

The rights specified in 850(9)(D)(3)(c) include the insured's right to:

a. Attend the second level review;
b. Present his or her case to the review panel;
c. Submit supporting material both before and at the review meeting;
d. Ask questions of any representative of the health carrier; and
e. Be assisted or represented by a person of his or her choice.

The sole reference to consumer's second level grievance rights in the May 24, 1999 adverse determination notice stated:

If you are not satisfied with this decision, and you wish further review of the claim, please write to the:

Management Grievance Committee
Healthsource Maine
2 Stonewood Drive
PO Box 447
Freeport ME 04032-0447

Should you have any further questions regarding this matter, please feel free to contact Debbie McClean, Appeals Coordinator at 1-800-524-9230, extension 5789.

27. On July 19, 1999, Consumer's provider again wrote to Healthsource, stating:

"I have enclosed a copy of the revised appeal response letter I received regarding [Consumer]. This revised appeal letter, as you can see, is dated July 15, 1999 and is a rewrite of the May 24, 1999 appeal response letter I received from Healthsource...

In spite of my requests and the requests of the Department of Professional & Financial Regulation, I have yet to receive a copy of the... reference or guide that Healthsource uses to complete the review. I need this information in order to assist my patient in completing her appeal to the Management Grievance Committee."

28. Rule 850(8)(E)(5) provides that adverse determination notices must contain the instructions for requesting the clinical review criteria used for making the initial adverse determination. Rule 850(8)(G)(1)(c)(iv) provides that adverse appeal decisions shall contain instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to the covered person.

29. Rule 850(8)(D)(1) provides that, *"A utilization review program shall use documented clinical review criteria that are based on published sound clinical evidence and which are evaluated periodically to assure ongoing efficacy. A health carrier or the carrier's designated URE may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors. Upon request, a health carrier or the carrier's URE shall make available its clinical review criteria to the Superintendent."*

30. On September 17, 1999, Healthsource wrote to the Bureau in response to the Bureau's request that Healthsource provide the Bureau, the Consumer, and the Consumer's provider with a copy of the current clinical review criteria for chiropractic services, and a copy of the clinical review criteria utilized at the time of the March 30, 1999 adverse determination. Healthsource advised:

> *"I am attaching correspondence from Dr. Kathy Naughton, a chiropractor employed by CIGNA with significant experience in clinical and academic chiropractic settings. She does not believe that currently there are objective clinical review criteria to serve as a benchmark for review. Rather, Healthsource and CIGNA nationally are forced to have their Medical Directors use general medical judgment in determining whether a condition will improve within the stated short term period defined in the member's Group Subscriber Agreement."*

A copy of Dr. Naughten's letter is appended to this Agreement as Exhibit "A".

CONCLUSIONS OF LAW

31. As set forth in paragraphs 5, 6, 7, and 8 above, Healthsource violated Rule 850(8)(G)(1)(c) by failing to provide a written response to Consumer's appeal within 20 days.

32. As set forth in paragraphs 9, 10, 11, 14, and 17, above, Healthsource violated Rule 850(8)(G)(1)(c)(i) by failing to include the name of the reviewing clinical peer in its May 24, 1999 adverse determination notice.

33. As set forth in paragraphs 12, 14, 18, 19, and 20, 21, 22 and 23 above, Healthsource violated Rule 850(8)(G)(1)(c)(iii) in its May 24, 1999 and July 15, 1999 adverse determination notices by failing to articulate the reviewers' decision and clinical rationale in sufficient detail for the covered person to respond further to Healthsource's position. Advising a consumer that a treatment "is not medically necessary" is conclusory because it does not advise the consumer why the treatment is not medically necessary. Healthsource's explanation that the treatment is not "*(1) Consistent with the symptoms or diagnosis and treatment of the member's condition,*" is likewise conclusory. It does not advise the Consumer why the treatment recommended by Consumer's provider is not consistent with the symptoms or diagnosis. Advising a consumer that a treatment *"does not reflect the most efficacious or effective care possible for this diagnosis"* is conclusory because it does advise the consumer why the treatment does not reflect the most efficacious or effective care possible. Healthsource's explanation that the treatment recommended by Consumer's provider is not "*(6) The most appropriate supply, level of care or service which can be safely and effectively provided to the Member"* is likewise conclusory. It does not advise the Consumer why the proposed treatment is not the most appropriate level of care which can be safely and effectively provided.

34. As set forth in Paragraph 26, above, Healthsource violated Rule 850(8)(G)(1)(c)(v). Consumer was not advised of the procedures and time frames governing a second level grievance review, or of her right to: 1) attend the second level review, 2) present her case to the review panel, 3) submit supporting material both before and at the review meeting, 4) ask questions of any representative of the health carrier, and 5) be assisted or represented by a person of his or her choice.

COVENANTS

35. A formal hearing in this matter is waived and no appeal will be made.

36. At the time of executing this Agreement, Healthsource will pay to the Maine Bureau of Insurance a civil penalty in the amount of four thousand dollars ($4,000), payable to the Treasurer of the State of Maine.

37. Within 30 days of executing of this Agreement, Healthsource will provide the Bureau with a written explanation of how it determines medical necessity for chiropractic services. Until such time as Healthsource may develop or adopt formal chiropractic clinical review criteria, Healthsource will advise consumers and their providers who request the clinical review criteria upon which an adverse chiropractic utilization review was based that Healthsource does not utilize chiropractic clinical review criteria. Requesting consumers and their providers will instead be provided with the aforementioned written explanation of how Healthsource determines medical necessity for chiropractic services, along with a detailed, patient specific justification for the adverse chiropractic determination at issue.

38. In consideration of Healthsource's execution of and compliance with the terms of this Consent Agreement, the Superintendent agrees to forgo pursuing any disciplinary measures or other civil sanction for the violations relating specifically to Bureau complaint # 1999505205 other than those agreed to in this Consent Agreement.

MISCELLANEOUS

39. This Consent Agreement may only be modified by the written consent of the parties.

40. It is understood by the parties to this Agreement that nothing herein shall affect any rights or interests that any person not a party to this Agreement may possess.

41. Healthsource acknowledges that this Consent Agreement is a public record within the meaning of 1 M.R.S.A. § 402 and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408.

42. Healthsource has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this Agreement.

FOR HEALTHSOURCE MAINE, Inc.

Dated: 11/18, 1999

By: R.M White
Signature

For: R. M. White
Typed Name

General Manager
Typed Title

this 18th day of Nov., 1999.

Teresa J Bennett
Notary Public
Comm. Exp. 8/31/03

FOR THE BUREAU OF INSURANCE

Dated: 11/23, 1999

Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, SS.

Subscribed and sworn to before me
this _____ day of _____, 1999.

_____
Notary Public/Attorney-at-Law

FOR THE MAINE ATTORNEY GENERAL

Dated: Nov. 23, 1999

Judith Shaw Chamberlain
Assistant Attorney General

Healthsource®
A CIGNA HealthCare Company

September 17, 1999

Norm Stevens
Consumer Health Care Division
State of Maine
Department of Professional and Financial Regulation
Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Response to DOI regarding Clinical Criteria

Dear Mr. Stevens:

This letter is in response to your communication dated August 31, 1999 to Michelle Bubar, of Healthsource Maine Inc. and specifically addresses covenant 36 which requests documentation of the clinical review criteria for chiropractic services. I have enclosed my academic and professional credentials with this response.

The current clinical review criteria for chiropractic services are the same criteria utilized to review allopathic and osteopathic services in the absence of established diagnosis specific clinical guidelines for services. Healthsource Maine Inc. maintains parity in its review criteria for all health care professionals' services in the absence of established guidelines by utilizing:

1. medical necessity criteria (as required in the group subscriber's agreement)
2. review of relevant case materials including medical records for review of objective criteria to establish diagnosis and treatment parameters
3. objective indications of patient improvement as a result of the established treatment.

The case cited in your communication was reviewed based upon these criteria and the determination rendered. As there are no diagnosis specific standards of care as defined by the chiropractic profession for the member's condition, Healthsource Maine Inc. could not utilize such guidelines in its determination of this case.

The only generally recognized specific guidelines developed for low back pain are those established by the United States Agency for Health Care Policy and Research (AHCPR) which recommends the use of spinal manipulation for a limited period of time for the treatment of acute, non radicular, mechanical, low back pain. The AHCPR guidelines

indicate "manipulation can be helpful for patients with acute low back problems without radiculopathy when used within the first month of symptoms. (Strength of Evidence = B.)" [i] As the case records indicate, the patient presented with a radicular pain pattern ("radiating pain which goes down the entire right leg") and therefore these guidelines are not applicable to this case.

There are no other guidelines as established through peer review literature and adapted through consensus by the chiropractic profession that are available at present time to utilize when reviewing chiropractic treatment and services. The only currently recognized chiropractic specific consensus guidelines based upon literature review and scientific evidence are the Guidelines for Quality Assurance and Practice Parameters as established in the proceedings from the Mercy Conference in 1993. These guidelines address broad areas of patient care such as History and Physical Examination, Clinical Record Keeping, Contraindications and Complications, Modes of Care and Frequency and Duration of Care however they do not address specific treatment programs of care related to specific diagnoses. The Modes of Care chapter rates the variety of manipulative techniques and physiological therapeutic modalities commonly utilized to treat conditions but does not recommend diagnosis specific procedures. The Frequency of Care chapter provides only general timeframes for the resolution of cases. However as stipulated in the chapter on Frequency and Duration of Care, these "guidelines are not prescriptive or cook book procedures for determining the absolute frequency and duration of care. It is also recognized in this chapter that guidelines do not relate to specific clinical conditions. The disclaimer to the Mercy Conference Guidelines document states: "these guidelines, which may need to be modified are intended to be flexible. They are not standards of care and adherence to them is voluntary. The commission understands that alternative practices are possible and may be preferable under certain conditions".[ii] An infrastructure to evaluate and oversee future revisions has been established by the Congress of Chiropractic State Associations.

Other than the Mercy Conference guidelines there have been some recent studies on standards of care however these have not received consensus and validation from the profession. These have occurred in Canada and Australia (Henderson, 1994; Ebrall, in press). Like the Mercy Conference Guidelines, "both used explicit processes to evaluate the literature and synthesize expert opinion on which the recommendations are based. These efforts update Mercy by incorporating new information however their recommendations were generally similar to those of Mercy.[iii]

Consequently the Mercy Conference guidelines still reflect the latest consensus document with regard to chiropractic guidelines. Further attempts to promulgate new consensus guidelines have been unsuccessful in light of the variety of practice parameters and belief systems that have developed within the chiropractic profession. A dualistic construct among chiropractors relative to philosophical approach and treatment protocols continues to exist today which renders consensus on guidelines development challenging. This dichotomy is perpetuated by the two distinct national trade associations: the American Chiropractic Association (ACA) and the International

Chiropractic Association (ICA). The ACA is generally considered to be the mainstream organization and includes approximately 25% of US chiropractors as members. The ICA reflects a radically more narrow approach to diagnostic and treatment parameters ("straight chiropractic") but a broader approach to treatment scope – i.e. treatment of patients with organic, non neuromusculoskeletal disease (cancer, developmental diseases, etc.) and includes approximately 5-10 % of US chiropractors. This faction of chiropractic attempted to develop its own guidelines in 1993 that reflected this narrow scope of ("straight") practice parameters however these lacked an explicit process and involvement of different viewpoints. "The recommendations promoted lengthy periods of treatment and did not consider evidence contrary to the sponsor's beliefs. The proceedings quickly went out of print and have not been reissued although a second effort has been undertaken."[iv]

These internal differences among members of the profession has obviated its ability to move forward with the development of specific guidelines. However there is a need recognized by the mainstream of the profession to develop appropriate and cost efficient guidelines. "The profession needs to improve the quality, effectiveness and efficiency of its care. Efforts need to be undertaken to determine the types, amounts and duration of chiropractic care that are the most cost efficient and appropriate for different clinical circumstances. This will require the chiropractic profession to pay increased attention to practice variation. Gaining a better understanding of the causes of variations in practice, determining which of these variations are inappropriate and finding ways to minimize undesirable variations should become professional priorities".[v]

In recognition of the fact that there are no uniform guidelines established for the profession, the American Chiropractic Association (ACA) has stipulated in its *Policies on Public Health and Related Matters*: "Standards of care are rapidly being developed by government and private professional organizations including the American Medical Association. These standards will ultimately be utilized under the Medicare outcomes assessment program and eventually utilized by third party payers."[vi] They further resolve: "Resolved that the House of Delegates determines that a state of emergency exists in relation to the current establishment of standards of care for the chiropractic profession" and directed the uses of funds for the ongoing development and support of Mercy Conference standards of practice.

Accordingly, as a consequence of the lack of recognized clinical guidelines as established by the chiropractic profession, Healthsource Maine Inc. has relied on the review criteria as cited above (medical necessity, appropriate documentation and objective evidence of clinical improvement) that it utilizes for review of non chiropractic providers. This maintains the integrity of the review process as it is not biased by profession. Reliance on medical necessity criteria is implicit under the member's group service agreement and is clearly recognized by the chiropractic profession. As per the ACA's *Policies on Public Health and Related Matters*: "Third party contracts usually call for a direct relationship between covered benefits and medical necessity. There is also much concern in this area by federal and state legislators, particularly as it pertains to

quality assurance and professional standards review organizations. The ACA agrees there should be a responsible position relative to this by our profession and has researched the subject as it is understood by numerous third party payers. The ACA position refers to those appropriate examinations, therapeutic substances and treatment procedures that are used by licensed practitioners too diagnose and treat patients with a specific condition. Implied is the fact that the condition be a recognized one and that the examinations, test, therapeutic substances and treatment procedures used are based upon scientific principles and studies, are generally accepted by the profession as being needed, essential and appropriate to properly diagnose and treat patients with a particular condition. Quality and quantity of examination and therapeutic procedures must be within the norms or criteria established by the profession as a whole for such a condition. Implied also is the fact that there must be documentation in the medical records and or reports to substantiate the need for services rendered."[vii].

Healthsource Maine Inc. applied medical necessity criteria to the case and approved initial treatment. However, ongoing treatment was not approved based upon the documentation provided by the chiropractic physician which did not utilize or report significant objective findings related to the patient. The orthopedic tests cited in the provider's previous narrative were not repeated or at least not documented and the patient had subjectively greatly improved. Consequently there was no documentation upon which to justify ongoing care that was medically necessary. As stated in the ACA reference above there is a need to justify ongoing treatment through adequate documentation of objective examination findings. The narrative of March 19, 1999 did not include adequate documentation of objective findings related to the patient.

I hope this adequately addresses your concerns and fulfills Healthsource Maine, Inc.'s response to the covenants referenced in your letter.

Sincerely

Kathleen Naughton DC

Kathleen M. Naughton, D.C., MHA
AVP, Quality and Process Improvement
Network Operations
CIGNA HealthCare

Executive Biography

Kathleen M. Naughton, D.C., M.H.A.
Assistant Vice President
Network Operations

Dr. Kathleen M. Naughton is Assistant Vice President in Network Operations for CIGNA Health Care (CHC). Prior to joining CHC, Dr Naughton was in clinical practice and was on the faculty of Logan College of Chiropractic for seven years. There she served as a clinician and an Associate Professor in the Health Center Division. In that capacity Dr. Naughton was responsible for developing the clinical curriculum and overseeing the clinical training and student internship program. She also developed and supervised the three level clinical competency examinations requisite for graduation. In addition, Dr. Naughton has been an item writer for the National Board of Chiropractic Examiners and assisted in the development of the Part III National Board Examination that states are currently adopting in lieu of licensing exams. Dr. Naughton was the Clinical Editor for the Foundation for Chiropractic Education and Research's *Journal of Spinal Manipulation* for 7 years and has been an editor for other journals including the *Journal of Chiropractic Education, Chiropractic Sports Medicine* and *Topics in Diagnostic Imaging.*

Dr. Naughton received her bachelor's degree from Assumption College in Worcester, MA in biology and her chiropractic degree and Acupuncture training from the National College of Chiropractic in Lombard, IL in 1986. She is board certified as a Diplomat from the American Chiropractic Board of Sports Physicians and earned appointments as Secretary-Treasurer and Vice President of the American Chiropractic Board of Sports Physicians in 1994 and 1995. Since joining CHC she assisted in the development of CHC's Low Back Pain disease management program and was appointed as an Expert Panel Member for Patient Education Media through Time-Life Medical. She received her Master's Degree in Health Administration from the Medical College of Virginia, Virginia Commonwealth University in 1998 and is a member of the American College of Health Care Executives.

Footnotes

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[i] Bigos S, Bowyer O, Braen G, et al. Acute Low Back Problems in Adults: Clinical Practice Guideline, No.14, AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, US Dept. of Health and Human Services, December 1994.

[ii] Haldeman S, Chapman-Smith D, Petersen D (eds). Guidelines for Chiropractic Quality Assurance and Practice Parameters. Gaithersburg, MD: Aspen Publishers, 1993.

[iii] Chiropractic in the United States: Training, Practice, and Research, project supported by grant number HS07915 from the Agency for Health Care Policy and Research, AHCPR Publication No. 98-N002
December 1997

[iv] Ibid

[v] Ibid

[vi] 1998-1999 ACA Directory of Members and Buyers Guide, American Chiropractic Association on Public Health and related Matters, American Chiropractic Association, Clarendon Virginia, 1998

[vii] Ibid

ANGUS S. KING, JR.
GOVERNOR

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ALESSANDRONI TOPPA
SUPERINTENDENT

LHF 700

STATE OF MAINE
BUREAU OF INSURANCE
Docket No. MCINS 99-13

In re: UNITED HEALTHCARE INSURANCE COMPANY) CONSENT AGREEMENT

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among United HealthCare Insurance Company, (hereafter also United HealthCare and the Superintendent of Insurance (hereafter "the Superintendent"). It's purpose is to resolve, without resort to an adjudicatory proceeding, violations of Bureau of Insurance Rule Chapter 850, hereafter also "Rule 850," as described below.

FACTS

1. The Superintendent of Insurance is the official charged with administering and enforcing Maine's insurance laws and regulations.

2. United HealthCare Insurance Company, license # LHF 700 has been licensed as a Life and Health Insurer in Maine since 1972.

3. United Healthcare employed HealthPlan Services, Inc., formerly known as Consolidated Group Inc., to administer claims from at least March of 1998, until at least July of 1998. HealthPlan Services is a licensed Third Party Administrator, license # TAF32930. United HealthCare is responsible for the acts of HealthPlan Services.

4. Consumer, whose true name has been omitted for protection of privacy, was insured, at all times relevant to this Consent Agreement, under a health insurance policy issued by United HealthCare.

5. Benefits under Consumer's policy are subject to Utilization Review. The policy provides that services and supplies proposed by the patient's Physician can be pre-approved as medically necessary by the Patient Advocate. The policy states, "*if you call the Patient Advocate before charges are incurred you will know which charges are Medically Necessary.*" Charges determined not to be medically necessary are not

covered expenses. Consumer's policy includes the following instruction for obtaining pre-authorization for medical services (emphasis added):

- You must notify the Patient Advocate for any of the services shown below:
  - Confinement in any of the following facilities: A Hospital.
- How to notify the Patient Advocate: The Patient Advocate is notified by call the toll-free number shown on your health insurance ID card.
- The patient Advocate will ask for all of the following:
  - Medical information concerning the confinement, surgical procedure, diagnostic procedure or treatment plan.
  - Physician's name, phone number and address.
- **The Patient Advocate will then complete the Utilization Review. You, your physician and the Hospital will be sent a letter confirming the results of the Review within 5 days of the date the Patient Advocate is notified.**

6. Consumer's policy covers the following medically necessary transportation services.
   - By professional ambulance, other than air ambulance, to and from a hospital or medical facility.
   - By regularly scheduled airline, railroad or air ambulance, to the nearest hospital qualified to give the required treatment.

7. On March 30, 1998 Consumer called HealthPlan Services to obtain authorization for transportation to a non local sleep disorder clinic recommended by her doctor. This phone call was required by, and in compliance with, her policy. Under the terms of the policy, set forth in paragraph 5, United HealthCare, through its representative, should have:

   a.) asked for information concerning the treatment plan;
   b.) requested the physicians name, phone number and address, and
   c.) completed a Utilization Review regarding the requested services.
   d.) The policy requires that the Consumer and the Hospital "will be sent a letter confirming the results of the Review within 5 days of the date the Patient Advocate is notified. Timely notice of Utilization Review decisions is also mandated by provisions of Rule 850, set forth below.

> Rule 850(D)(3)(a). "A health carrier or the carrier's designated URE shall issue utilization review decisions in a timely manner pursuant to the requirements of subsection F,G and H.
> (a) A health carrier or the carrier's designated URE shall obtain all information require to make a utilization review decision, including pertinent clinical information."
>
> Rule 850(8)(E)(2). "For initial determinations, a health carrier or the carrier's designated URE shall make the determination and so notify the covered person and their provider within 2 working days of obtaining all necessary information regarding a proposed

procedure or service requiring a review determination. A carrier or the carrier's URE shall make a good faith effort to obtain all necessary information expeditiously, and is responsible for expeditious retrieval of necessary information in the possession of a person with whom the health carrier contracts."

8. The telephone logs from Consumer's **March 30, 1998,** call to HealthPlan Services documented that Consumer was initially informed on that date that transportation would only be covered for emergency purposes. In fact, as HealthPlan Services acknowledged by letter of May 13, 1998, "Consumer was correct in stating that the benefit booklet does not indicate that the ambulance service must be for 'emergency services' only."

9. The telephone logs from Consumer's **March 30, 1998,** call to HealthPlan Services also documented that Consumer was advised that *"if you can get a letter from your doctor of medical necessity.....you need to send the letter to me and I can send this information to the carrier for a priority review."*

10. On or about **April 6, 1998,** Consumer filed a complaint with the Bureau of Insurance. The relevant portion of the complaint is set forth below.

> *"I spoke with Louise at Health Plan Services on 3/30/98 re: the insurance company paying for transportation to a medical ctr. in another state (NH). She said it had to be "an emergency" to have the ins. co pay for trans. However, on pg. 54 of the manual, only "medically necessary trans. Services" is mentioned, & it falls under Comprehensive medical coverage. Clearly emergency services is not even indicated!"*

11. The Bureau of Insurance forwarded the complaint to United HealthCare for a response on **April 10, 1998.**

12. On **April 23, 1998,** Consolidated Group Inc. (now HealthPlan Services) wrote to the Bureau of Insurance. This letter incorrectly stated that the Consumer had made a request for round trip ambulance service, when that had not in fact been requested. HealthPlan Services also improperly indicated the responsibility lay with the Consumer to obtain documentation that was the carrier's obligation to obtain under Rule 850(E)(2). Consumer's policy states the Patient Advocate will complete the Utilization Review and notify the patient the results within 5 days. Relevant excerpts of the April 23, 1998, letter are set forth below. (Emphasis added.)

> *"Our records indicate that Consumer contacted our office on March 30, 1998, in an attempt to obtain pre-authorization for round trip ambulance transportation from her residence in Maine to a facility located in Vermont where she would undergo diagnostic sleep studies.*

The Comprehensive Medical Benefit section of the booklet indicates that this plan pays for medically necessary transportation services by professional Ambulance, other than air ambulance, to and from a hospital or medical facility; or by regularly scheduled airline, railroad or air ambulance, to the nearest hospital qualified to give the required treatment...

Medical necessity was questioned by the customer service representative at the time of the inquiry. ***Consumer was advised that a letter of medical necessity from her physician should be submitted for further review by the carrier.*** *As of the date of this letter, we have not received any documentation related to this service. A letter of medical necessity for the sleep study should also include information as to why the nearest facility equipped to perform a sleep study is out of state and five hours away from [Consumer's] home.*

13. On **May 6, 1998,** the Bureau of Insurance wrote to Consolidated Group, requesting a copy of Consumer's health plan booklet along with all amendments and riders. Pursuant to 24-A § 220-A the carrier was required to respond to this request within 14 days.

14. On **May 12, 1998,** Consumer's provider sent a letter to Consolidated Group Inc. (now HealthPlan Services) addressing the need for sleep disorder treatment. An excerpt from this letter is set forth below.

"[Consumer] presented to [provider] stating a long standing history of sleep disorders...She states that she had previously been evaluated by two Maine physicians who have expertise in sleep disorders; however, all treatments thus far have apparently been unsuccessful. Because of the significant effect that [Consumer's] disorders have on the quality of her life, it has been deemed medically necessary for Consumer to be evaluated and treated at the [Sleep Disorder Clinic] as they have medical equipment that can provide adequate testing for Consumer–equipment that is not available to her in this state."

15. Rule 850(E)(2) requires a carrier conducting Utilization Review to expeditiously obtain any additional information it considers necessary, and respond to the consumer and provider within two days of receiving all necessary information. Neither Consumer nor provider received any response within two days to provider's May 12, 1998, letter.

16. On **May 13, 1998,** HealthPlan Services wrote to the Bureau of Insurance.

"Consumer is correct in stating that the benefit booklet does not indicate that the ambulance service must be for "emergency" services only. However, the benefit booklet does state that benefits are available for Medically Necessary Transportation Services. For this reason we request a letter of medical necessity [for] any transportation services."

17. On **June 18, 1998,** the Bureau wrote to HealthPlan Services, again requesting a copy of the Consumer's health plan. A copy of Consumer's health plan which was first requested on May 6, 1998.

18. On **July 9, 1998,** over two months after it was requested, HealthPlan Services wrote to the Bureau of Insurance, enclosing a copy of Consumer's policy. The letter states, (emphasis added): *"I have reviewed the letter of medical necessity you included from [provider], however, this letter does not indicate the medical necessity for an ambulance. Therefore, we cannot authorize an ambulance for this service."* As discussed at paragraph 6, Consumer did not request authorization for an ambulance.

19. On **July 23, 1998,** HealthPlan Services wrote to the Bureau of Insurance stating, in relevant part:

> *"In order to review Consumer's file we will need a letter explaining the medical necessity for transportation. We need to know why Consumer cannot transport herself from Maine to New Hampshire in order to perform the services she is in need of. Please indicate what form of transportation Consumer is requesting."*
>
> *Once this information is received, I will forward her file to the insurance carrier for review."*

20. On or about **July 24, 1998,** the Bureau of Insurance wrote to HealthPlan Services, stating:

> *"As I explained to you in our phone conversation of July 22, 1998, Consumer is not making a request for ambulance service. In accordance with her plan she is requesting coverage for the expense of transportation by either a regularly scheduled airline, railroad or air ambulance...I am once again providing you with a copy of the letter from Consumer's doctor's office indicating the need for treatment at [Sleep Disorder Clinic]. Also, I am enclosing a copy of the message I received form her doctor's office, pursuant to your July 23rd letter, indicating that there are potential risks. Her ability to concentrate while driving such a long distance should be a concern. The mode of travel to New Hampshire can be determined fairly, I trust, by the plan's Patient Advocate..."*

21. On or about **July 24, 1998,** the Bureau of Insurance forwarded [Provider's] July 23, 1998, letter regarding medical necessity for transportation to HealthPlan Services. [Provider's] letter stated:

> *"Consumer has stated that she does not feel that she can safely transport herself to her out of state appointment for evaluation of her sleep disorders. I agree that there is a possible risk associated with her driving for such a distance for not only herself but for others on the road as well."*

22. On **July 30, 1998,** HealthPlan Services wrote to the Bureau of Insurance, and acknowledged *"receipt of your letter and supporting documentation concerning the proposed transportation services for Consumer. All submitted material has been forwarded to the insurance carrier for review."*

23. On **August 21,1999**, HealthPlan Services notified Consumer of its adverse determination, stating:

> *"The transportation is not required for diagnostic testing. The proposed transportation provides no medical services. It is also not the least intensive means of transportation. In addition, [Sleep Disorder Clinic] is not the nearest facility qualified to provide services related to sleep disorders. It has been determined that the benefits for transportation to the [Sleep Disorder Clinic] are not available under the plan."*

United HealthCare failed to acknowledge and address the May 12, 1998, letter from Consumer's provider, which clearly stated that the [Sleep Disorder Clinic] in New Hampshire has **"medical equipment that can provide adequate testing for Consumer– equipment that is not available to her in this state."**

24. In its letter of **August 21, 1998,** HealthPlan Services advised that the Consumer's policy clearly states, *"services and supplies proposed by your Physician can be pre-approved as Medically Necessary by the Patient Advocate. If you call the Patient Advocate before charges are incurred you will know which charges are Medically Necessary."* This is what Consumer attempted to do on March 30, 1998, when she called HealthPlan Services and spoke with customer representatives. At that time she was told transportation was not covered because it was not a life threatening emergency, a reason inconsistent with her policy.

25. In its **August 21, 1998** letter, after over four months of effort on the part of Consumer and the Bureau, HealthPlan Services denied the consumer's request on the ground of lack of medical necessity. The same letter states, *"the consumer has not initiated any formal request for a determination of benefits in regard to either the transportation or the testing/treatment to be rendered."* As set forth below, this letter once again indicated that the request for coverage was not accompanied by certain listed information which had never been previously requested, and which the carrier was responsible for obtaining.

> *"In regards to the proposed treatment at [Sleep Disorder Clinic], there has been no request for a determination of the proposed services. No clinical documentation was submitted reflecting the specific testing/treatment to be rendered. Therefore, we cannot substantiate the medical necessity for the proposed services.*

Consumer has not initiated any formal request for a determination of benefits in regards to either the transportation or the testing/treatment to be rendered.

- *If Consumer wishes to do so, she may submit the following information: Complete history/physical*
- *Prior evaluation and treatment for sleep disorder, diagnostic test results*
- *Specifics regarding what testing and treatment is proposed at [Sleep Disorder Clinic]*
- Clinical documentation substantiating the proposed transportation meets *the above definition of medically necessary transportation services."*

26. The **August 21, 1998** letter from HealthPlan Services did not contain instructions for filing an appeal. This letter was an adverse determination notice and as such was required to comply with Rule 850(8)(E)(5), which provides:

> *"A written notification of an adverse determination shall include the principal reasons or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rational, including the clinical review criteria used to make the determination. The notification must include a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration and/or requesting clinical rational and review criteria. The carrier or the carrier's designated URE shall respond expeditiously to such written requests."*

27. On **September 10, 1998** the Bureau of Insurance wrote a detailed letter to United HealthCare explaining how, in the Bureau's view, Consumer's request for pre-authorization had been severely mishandled.

28. On **September 18, 1998** HealthPlan Services wrote: *"On July 30, 1998 I received all the information necessary in order to have this file reviewed. I sent you a letter stating all the information was sent to the carrier for review of medical necessity. I received a reply from the carrier and sent you a letter on August 21, 1998 stating that the carrier has reviewed the file and determined that the transportation was not medically necessary. They also indicated that in order to review the file to determine if the sleep study was medically necessary additional information was needed."*

29. This medical necessity determination took from 7/30/98 to 8/21/98. The adverse determination was sent 21 days after United HealthCare acknowledged it received "all information necessary in order to have this file reviewed."

30. Title 24-A M.S.R.A. § 4304(2) requires that, "requests by a provider for prior authorization of a non emergency service must be answered by the carrier within 2 business days. If the information submitted is insufficient to make a decision, the

carrier shall notify the provider within 2 business days of the additional information necessary to render a decision."

31. In response to an inquiry by the Bureau of Insurance concerning licensure, HealthPlan Services advised in its letter of **September 18, 1998** that, "HealthPlan Services is not a Utilization Review Entity therefore we cannot provide a license number. The Utilization Review Organization is Patient Advocate. However, this type of procedure does not require a review by Utilization review. Page 28 of Consumer's policy booklet lists all procedures which require a review by Patient Advocate..."

32. In its letter of **September 18, 1998,** HealthPlan Services stated in relevant part:

> *"You state that Consumer did initiate a formal request for a determination of benefits. We have never received a written predetermination letter from her physician. A predetermination should include the procedure to be performed and any medial documentation to substantiate the proposed service. Therefore, we were not able to provide a written notification to Consumer, her physician or yourself."*

33. United HealthCare sent the Bureau of Insurance a letter post-marked **October 7, 1998,** indicating that its relationship with HealthPlan Services had ended in June of 1998. Excerpts from this letter are set forth below.

> *"Thank you for bringing this matter to United HealthCare's attention. I have reviewed this matter and have determined that Health Plan Services (HPS) no longer has a relationship with United HealthCare (UHC) as of approximately June 1998 in the state of Maine...In our relationship with HPS, all utilization review decisions were to be made by United HealthCare. My review indicates HPS sent the file to UHC for review. The resolution revealed more documentation was needed to make a benefit determination. Thus, we are very concerned about these charges.*
>
> *We would like to expedite this matter. UHC will request the documentation from the physician/member and obtain all the necessary information relative to determine benefit coverage. Medical necessity guidelines will be reviewed by Unite HealthCare upon receipt of Consumer's file."*

34. On **October 12, 1998,** United HealthCare sent a letter to the Consumer again requesting more information from the Consumer. Excerpts from this letter are set forth below.

> *"We have no clinical information to substantiate the medical indication for the proposed sleep study. There is an indication in the record that you have been evaluated and treated by two local physician. The clinical information form you previous providers is not available for review. Information that should be submitted to support the reason for the requested test should include a current*

history and physical examination, your physician's explanation of a rationale for the current proposed testing as well as a clarification of what specific testing is proposed to be performed at [Sleep Disorder Clinic] that can not be performed at a local facility."..... We would like the opportunity to proceed with the evaluation of your request. To do so, please submit the following medical information within sixty (60) days of receipt of this notice:

- *Complete history and physical*
- *Complete medical record form your previous providers to include medical evaluations*
  And results of treatment for sleep disorders, diagnostic test results
- *Specifics regarding what testing and treatment is proposed at [Sleep Disorder Clinic]*
- *Documentation to support that [Sleep Disorder Clinic], a facility located five hours from you, is the closest facility available to perform the specific required testing.*

35. On **November 12, 1998** United HealthCare sent a letter to the Consumer, again advising the Consumer that they required additional information. The letter states:

> *"We have received a response to the October 14, 1998 letter from the [provider]. The physician's office explained that there was no record of your previous sleep work up at the [provider's] practice as they had not performed any of the previous testing. They advised that you will have to provide that documentation from your other physicians to support the need for your requested testing."*

CONCLUSIONS

36. United HealthCare is responsible for the acts of its subcontractor, HealthPlan Services.

37. As set forth in paragraphs 8,10, and12, United HealthCare violated Title 24-A M.R.S.A. § 2153 by misrepresenting the terms of Consumer's policy.

38. As set forth in paragraphs 9,12, 16, 18, 19, 25, 31, and 32, United HealthCare and HealthPlan Services failed to correctly explain what Consumer was required to do to obtain pre-certification of benefits.

39. As set forth in paragraphs 9, 12, 16, 18, 19, 25, 28, 32, 34, and 35, United HealthCare violated Rule 850(8)(E)(2) and the terms of its own policy by repeatedly advising Consumer that it was her obligation , rather than United HealthCare's, to obtain medical documentation. United HealthCare did not make a good faith effort to obtain all necessary information expeditiously.

40. As set forth in paragraphs 23-26, United HealthCare violated Rule 850(8)(E)(2), by failing to provide a written notification of adverse determination that included the principal reasons for the determination, the instructions for initiating an appeal for reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.

41. United HealthCare failed to communicate with Consumer and her provider in a timely manner. In particular, United HealthCare failed to comply with the requirements of 24-A M.S.R.A. § 4304(2), which requires that, "requests by a provider for prior authorization of a non emergency service must be answered by the carrier within 2 business days. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision." See paragraphs 14 – 16, and 21-35.

42. United HealthCare failed to adequately or timely respond to the Bureau of Insurance, in violation of Title 24-A M.R.S.A. § 220(2). See paragraphs 13, 17, and 18.

43. As the facts set forth above chronicle, United HealthCare failed to fulfill its obligations under Rule 850 and under its policy. Despite extensive efforts by both the Consumer and the Bureau, the issue of pre-certification was not resolved for over six months.

COVENANTS

44. United HealthCare agrees to the imposition of a civil penalty of $20,000 for the violation recited above, pursuant to Title 24-A M.R.S.A. §§ 12-A(1), and shall submit a check for $20,000, payable to the Treasurer of the State of Maine, at the time of the execution of this Agreement.

MISCELLANEOUS

45. United HealthCare understands and acknowledges that this Agreement will constitute a public record within the meaning of 1 M.R.S.A. § 402 and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408.

46. It is understood by the parties to this Agreement that nothing herein shall affect any rights or interests that any person not a party to this Agreement may possess.

47. United HealthCare has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this agreement.

Dated: 7/29/99

For: United HealthCare

Subscribed to before me this 29th day of July, 1999.

By: Matthew Friedman
Signature

Matthew L. Friedman
Typed Name

Secretary
Typed Title

Karen J. Bombard
Notary Public/~~Attorney~~
ME 6/30/2002

FOR THE BUREAU OF INSURANCE

Dated: 8-9, 1999

Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, SS.

Subscribed and sworn to before me this 9th day of August 1999.

Martha E. Curtis
Notary Public/Attorney-at-Law

MARTHA E. CURTIS
NOTARY PUBLIC • MAINE
MY COMMISSION EXPIRES JULY 11, 2005

Dated: 8/18/99

J. Chamberlain
JUDITH SHAW CHAMBERLAIN
Assistant Attorney General
6 State House Station
Augusta, ME 04333-0006

Date: 8-9-99

Payer: UNITED HEALTHCARE CORP

Check #: 1150301 Amount: $20,000.00

Description: CONSENT AGREEMENT

Name: UNITED HEALTHCARE CORP = LHF700

THE FACE OF THIS DOCUMENT CONTAINS A MULTICOLORED BACKGROUND • THE BACK CONTAINS AN ARTIFICIAL WATERMARK (HOLD AT AN ANGLE TO VIEW) AND INK THAT RESPONDS TO TEMPERATURE.

UNITEDhealthcare

UNITED HEALTHCARE CORPORATION
P.O. BOX 1459 MN012-S211
MINNEAPOLIS MN 55440-8001

Fleet
150 Windsor St
Hartford CT 06120

51-44
119

272

DATE
08-05-1999 CHECK NO. 01150301

PAY ONLY 20,000.00

Pay TWENTY THOUSAND AND 00/100 DOLLARS

To The Order of
TREASURER STATE OF MAINE
24 STATE HOUSE STATION
AUGUSTA ME 04333-0024

AUTHORIZED SIGNATURE

ABSENCE OF ANY OF THE FEATURES MENTIONED ABOVE MAY INDICATE A FRAUDULENT DOCUMENT • DO NOT CASH UNLESS ALL FEATURES ARE PRESENT. CHECKS CLEAR POSITIVE PAY.

⑈0001150301⑈ ⑆011900445⑆ 51300⑈

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ANGUS S. KING, JR.
GOVERNOR

ALESSANDRO A. IUPPA
SUPERINTENDENT

IN RE: HEALTHSOURCE MAINE, INC.) **CONSENT AGREEMENT**
) **BUREAU OF INSURANCE**
) **DOC NO. MCINS 99-12**

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among Healthsource Maine, Inc. (hereafter "Healthsource") and the Superintendent of the Maine Bureau of Insurance (hereafter also "the Superintendent"). Its purpose is to resolve, without resort to an adjudicatory proceeding, a violation of the Maine Insurance Code as set forth below.

FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations.

2. Healthsource Maine, Inc has been a Maine licensed HMO, License # HMD4, since 1987.

3. Consumer, whose true name has been omitted for protection of privacy, was insured, at all times relevant to this Consent Agreement, under a health insurance policy issued by Healthsource.

4. Consumer filed a formal complaint, complaint # 1999504786, with the Bureau of Insurance challenging Healthsource's adverse utilization review determination, through two levels of appeal, of orthognathic surgery recommended by Consumer's oral surgeon.

5. On February 5, 1999, Healthsource sent Consumer an adverse first level appeal utilization review determination notice. Healthsource's first level appeal committee consisted of (names omitted, emphasis added): Quality Services Improvement Manager; RN, Manager Quality Improvement Department; Manager POS Product; Manager Marketing Department; Manager Claims Department; Manager Provider Services; **Associate Medical Director, Board Certified Pediatric Physician.**

6. Rule 850(8)(G)(1)(b) requires first level adverse utilization review appeals to be, "evaluated by an appropriate clinical peer or peers."

7. Rule 850 (5)(H) defines "Clinical peer" to mean "a physician or other health care professional who holds a non-restricted license in a state of the United States in the same or similar specialty as typically manages the medical condition, procedure or treatment

under review, or other physician or health care professional with demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision."

8. In response to Healthsource's adverse first level appeal determination, Consumer filed a second level grievance and on April 19, 1999 availed herself of her right to attend the second level grievance review and to be represented by legal counsel. The physician participating on the second level grievance review panel was the Healthsource Medical Director, a Board Certified Family Practice Physician. Consumer's attorney advised the grievance panel that Healthsource appeared to be in violation of Rule 850's clinical peer requirements.

9. On May 11, 1999, Healthsource sent Consumer an adverse second level grievance utilization review determination notice stating (emphasis added):

> *"The Committee reviewed your case and determined to grant your request to have the case reviewed by an independent reviewer. [The independent reviewer] reviewed your case file and has written to Healthsource Maine Inc. with his findings. Based on findings from [the independent reviewer], the Committee determined to uphold the denial based on the fact that medical necessity is not supported for the proposed surgery..."*
>
> *"The committee is structured so that when reviewing a medical case, we have 3 of the 5 members voting; [Medical Director], [RN, Manager Quality Improvement Department], and one other committee member. [The RN] was not present the day of your grievance, however, a decision was not made on April 19, 1999. In addition, [the RN] reviewed the grievance packet and was kept up to date on how the committee was proceeding with an independent review. The committee would not have rendered a vote unless [the RN] was present... In review of Rule 850, Healthsource believes it meets the Rule, specifically, "or other physician or health care professional with demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision". The Associate Medical Director who reviewed this appeal and [the Medical Director] who reviewed your grievance,* <u>have demonstrable expertise to review our guidelines</u> *for orthognathic surgery to determine medical necessity."*

10. Rule 850(9)(D)(2)(a) provides: *"For second level grievances involving an adverse utilization review determination, a health carrier shall appoint a second level grievance review panel for each grievance...The panel must include at least one health care professional who is a clinical peer and was not previously involved with the grievance ."*

11. Healthsource has advised the Bureau that at the time Consumer's initial request for services was reviewed, Healthsource believed its adverse decision process appropriately utilized "clinical peers." After engaging in discussions with the Bureau concerning the

requirements of Rule 850, Healthsource has agreed that the "clinical peer" requirement was not met with respect to this Consumer.

12. Rule 850(9)(D)(Rule 850(9)(D)(3) requires that members of the grievance panel be available for direct communication with the consumer at the second level grievance hearing.

13. Among other requirements, Rule 850(9)(C)(1)(b) requires adverse second level grievance decisions to notify consumers of their right to contact the Superintendent's office, and to provide the toll free number and address of the Bureau of Insurance. The May 11, 1999 adverse determination notice failed to contain notice of the covered person's right to contact the Superintendents Office, and failed to provide the toll free number and address of the Bureau of Insurance.

CONCLUSIONS

14. Healthsource failed to comply with the requirements of Rule 850(8)(G)(1)(b), in that Consumer's first level appeal was not evaluated by an appropriate clinical peer. The Associate Medical Director, a pediatric physician, does not have demonstrable expertise with respect to "orthognathic surgery," and therefore does not qualify as a "clinical peer" under the requirements of Rule 850.

15. Healthsource failed to comply with the requirements of Rule 850(9)(D)(2)(a), in that Consumer's second level grievance was not reviewed by an appropriate clinical peer. Healthsource identified the three voting members for the second level grievance procedure as the Medical Director, the RN, and the Director of Member Services referenced at paragraph 9 above. The Medical Director is a family practice physician. None of the three voting members of the second level grievance review panel were qualified under the requirement of Rule 850 to serve as "Clinical Peers" with respect to orthognathic surgery. The clinical peer requirement was not satisfied by the grievance panel's reliance on the report of an independent reviewer who did not participate as a member of the grievance panel at the April 19, 1999 grievance review.

16. Healthsource failed to comply with the requirements of Rule 850(9)(C)(1)(b) in its May 11, 1999 adverse determination notice to Consumer. The May 11th notice failed to notify the consumer of her right to contact the Superintendent's office, and failed to include the toll free number and address of the Bureau of Insurance.

COVENANTS

17. A formal hearing in this matter is waived and no appeal will be made.

18. At the time of executing this Agreement, Healthsource will pay to the Maine Bureau of Insurance a penalty in the amount of two thousand dollars ($2,000), payable to the Treasurer of the State of Maine.

19. In consideration of Healthsource's execution of and compliance with the terms of this Consent Agreement, the Superintendent agrees to forgo pursuing any disciplinary measures or other civil sanction for the actions described above other than those agreed to in this Consent Agreement.

MISCELLANEOUS

20. This Consent Agreement may only be modified by the written consent of the parties.

21. It is understood by the parties to this Agreement that nothing herein shall affect any rights or interests that any person not a party to this Agreement may possess.

22. Healthsource acknowledges that this Consent Agreement is a public record within the meaning of 1 M.R.S.A. § 402 and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408.

23. Healthsource has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this Agreement.

Dated: 11/18, 1999

For Healthsource Maine, Inc.

By: N. M. White
Signature

For: N. M. White
Typed Name

Group Manager
Typed Title

this 18th day of Nov., 1999.

Susan J. Bennett
Notary Public
Comm. Exp. 8/31/03

FOR THE BUREAU OF INSURANCE

Dated: 11/28, 1999

Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, SS.

Subscribed and sworn to before me
this _____ day of _____, 1999.

_____
Notary Public/Attorney-at-Law

FOR THE MAINE
ATTORNEY GENERAL

Dated: Nov. 23, 1999

Judith Shaw Chamberlain
Assistant Attorney General

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ANGUS S. KING, JR.
GOVERNOR

ALESSANDRO A. IUPPA
SUPERINTENDENT

IN RE: WASHINGTON NATIONAL INSURANCE COMPANY) **CONSENT AGREEMENT**) **BUREAU OF INSURANCE**) **DOC NO. MCINS 99-11**

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among Washington National Insurance Company (hereafter "Washington National") and the Superintendent of the Maine Bureau of Insurance (hereafter also "the Superintendent"). Its purpose is to resolve, without resort to an adjudicatory proceeding, a violations of the Maine Insurance Code as set forth below.

FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations.

2. Washington National has been a Maine licensed life and health insurance company, License # LHF294, since 1925.

3. Consumer, whose true name has been omitted for protection of privacy, was insured, at all time relevant to this Consent Agreement, under a health insurance policy issued by Washington National.

4. On February 23, 1999, Consumer filed a formal complaint, complaint # 1999504911, with the Bureau of Insurance objecting to a denial of her claim by Washington National. The complaint stated in relevant part:

> *I had major foot surgery in July 1997 – repaired tendons (torn) and removal of an evulsion FX – by Dr. Gregory Pomeroy. I had many problems [with] this surgery. Dr. Pomeroy thought it was medically necessary to unload the tendons to see if they would heal – he ordered orthotics 12-31-97. I went to purchase these via prescription (from Dr. Pomeroy) and before I saw the guy that was going to custom fit me for the orthotics I called Washington Nat. for the "OK". Brian Bystrom – a Washington National representative said yes to ahead your covered – so I did I paid $300.00 on 12/31/97 (my deductible was zero) I submitted the claim. I was refused. They said we and our medical staff feel you didn't need these – provide us [with] a note from your doctor saying it was medically necessary – which I did they said we still feel you didn't need these – so they refuse to pay me.!*

5. Washington National phone records document a telephone call from provider to Washington National on December 30, 1997. In a telephone call from the Bureau of Insurance to Washington National on June 29, 1999, Washington National's representative explained that this telephone record indicates that benefits for orthotics were approved during the provider's phone call of December 30, 1997. If the benefits had been approved or verified subject to medical necessity, there would have been a notation on the phone record indicating that a determination of medical necessity was required. Washington National has advised that this phone record indicates that benefits for orthotics were approved and that the consumer and provider were entitled to rely on that approval.

6. On April 22, 1998, Washington National sent Consumer an Explanation of Benefits denying the claim, with the remark:
   - *"information requested has not been received."*

7. On May 6, 1998, Washington National sent Consumer an Explanation of Benefits again denying the claim, with the remark:
   - *"Please submit itemized doctor bill which includes diagnosis."*

8. On November 6, 1998 Consumer's provider wrote Washington National a letter of medical necessity for orthotics following surgery for the repair of a torn tendon, stating:

   "Please note that [Consumer] is a patient of mine who has peroneal tendinitis of the left foot. She requires custom orthotics with a lateral wedge to unload the tendon. This will unload the tendon and provide pain relief while the tendon heals. In an attempt to treat her conservatively, I ordered custom inserts for her. I would greatly appreciate you considering covering the cost of the orthotics and custom shoes. If there is anything further you need, please contact me.

9. On December 7, 1998 Washington National sent Consumer an Explanation of Benefits denying the claim, and stating as grounds:
   - *"Claim does not support molded supports for the treatment of tendonitis."*
   - *"Charges not covered. Refer to policy exclusions/limitations."*

10. On January 14, 1999 Consumer's provider wrote a letter of Medical Necessity to Washington National, essentially identical to the medical necessity letter of November 6, 1998.

11. On February 16, 1999, Washington National wrote Consumer, advising:

    "We are in receipt of your correspondence requesting review of claim... for orthotics. After a medical review, by our medical review department, we have determined that the orthotics were not medically necessary. Therefore we are

unable to reconsider claim...for benefits. If you have any questions please contact our Customer Service Department."

12. Rule 850(8)(E)(5) requires carriers to notify their insureds in writing of any adverse utilization review determination. The notice must include:

    - *The principal reason or reasons for the determination.*
    - *The instructions for initiating an appeal for reconsideration of the determination.*
    - *The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.*
    - *A phone number the covered person may call for information on and assistance with initiating an appeal for reconsideration and/or requesting clinical rational and review criteria.*

13. Washington National's February 16th, 1999 adverse determination notice does not include:
    - The principal reasons for the determination.
    - The instructions for initiating an appeal for reconsideration of the determination.
    - The instructions for requesting a written statement of the clinical rational, including the clinical review criteria used to make the determination.
    - A phone number the covered person may call for information on and assistance with initiating an appeal for reconsideration and/or requesting clinical rational and review criteria.

14. On March 1, 1999, the Bureau of Insurance forwarded Consumer's complaint to Washington National, advising (emphasis added):

    "Please review the complaint and provide a detailed, substantive response to all issues raised. Your response must be supplemented by documentation in support of all representations, including, as applicable, all relevant notices, internal memos, file notes, phone logs or correspondence. In addition, please provide a copy of the policy at issue along with all relevant policy amendments and riders. Pursuant to Title 24-A M.R.S.A. §220(2), you must respond within 14 days after your receipt of this letter. Failure to provide a timely response that both meaningfully addresses all issues raised in the complaint and provides supporting documentation may result in disciplinary action."

15. On March 18, 1999 Washington National wrote the Bureau of Insurance. They advised that the policy:

    "is a Major Medical Expense plan, issued effective June 1, 1997. Policy page 6 (copy enclosed) lists the definition of Medical Necessity.

[Consumers'] claim for custom orthotics in the amount of $300.00 and [Provider's] letter of January 14, 1999, was reviewed by our Medical Unit. In accordance to their review, custom orthotics is not appropriate nor medically necessary for the treatment of tendinitis. Based on this information, the claim was denied. If [Consumer] wishes for us to review this claim again, she will need to submit medical records from Dr. Pomeroy.

Please be advised that we have reviewed our Customer Service records and find no record of [Consumer] calling our office regarding custom orthotics.

16. Rule 850(8)(D)(2) provides:

"A clinical peer shall evaluate the clinical appropriateness of adverse determinations."

17. Rule 850 (5)(H) defines "Clinical peer" to mean:

"a physician or other health care professional who holds a non-restricted license in a state of the United States in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, or other physician or health care professional with demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision."

18. The "medical unit" which Washington National referenced in its letter of March 18, 1999, and the "medical review department" referenced in its letter of February 16, 1999, do not qualify as clinical peers under Rule 850(5)(H) for the purpose of determining the medical necessity of Consumer's treatment. As documented by Washington National's Nurse Review Routing Sheet, dated December 1, 1998, the medical necessity determination was made solely by a Nurse Reviewer. Under the heading RECOMMENDATIONS, the nurse reviewer wrote, *"Unable to locate benefit for orthotics per policy provisions. Claim does support molded supports for the treatment of tendonitis."*

19. On March 19, 1999, the Bureau of Insurance wrote to Washington National:

"Thank you for your response of March 18, 1999 with attachments. As previously requested, please provide a complete copy of the claim file for the claim numbered above. The file should include al relevant notices, internal memos, file notes, telephone logs and all correspondence."

20. In its March 19, 1999 letter, the Bureau of Insurance advised Washington National that the company was not in compliance with the requirements of Rule 850, and requested that, *"Washington National Life Insurance Co. reconsider the decision to*

deny Ms. Gross' claim and take immediate steps to implement the standard under Chapter 850 in future handling of all claims falling under Maine jurisdiction."

21. On April 8, 1999, Washington National wrote to the Bureau of Insurance, and included the following enclosures.

    - Record of telephone encounter dated December 30, 1997 which documents that Washington National verified benefits for orthotics on that date. As set forth in paragraph 5 above, Washington National has confirmed to the Bureau of Insurance that Washington National agrees that based on the December, 30, 1997 telephone record the consumer and provider had a right to expect that the claim would be paid.
    - Letter of Medical Necessity dated November 6, 1998 from patient's provider, requesting coverage for orthotics. This letter included a hand written note from consumer, stating: "*Dear MMIU, I've given you all the information you asked for regarding this claim – I've been trying to collect since 1997 Dec. Please pay me the $300.00 I've got coming to me.*"
    - *Nurse Review Routing Sheet dated December 1, 1998. Under the heading RECOMMENDATIONS, the nurse reviewer wrote, "Unable to locate benefit for orthotics per policy provisions. Claim does support molded supports for the treatment of tendonitis."*

22. In its April 8, 1999 letter, Washington National stated (emphasis added):

    *"Pursuant to your request, enclosed are copies of all correspondence we have on file related to the orthotic that [Consumer] received on December, 30, 1997, in the amount of $300.00. As previously indicated [Consumer] does not have coverage for orthotics. However, **a review of our telephone records indicates that June White, of Picurro's Prosthetic Orthotic called our Customer service Department on December 30, 1997, and that a claim representative verified benefits for orthotics.**" Based on this information, we have decided to reconsider the claim. Once the claim has been reconsidered, we will forward a copy of the Explanation of Benefit's form to your office."*

    "Please be advised that our Utilization Review Entity was never contacted about orthotics. Therefore, we do not feel that Maine's Revised Rule, Chapter 850, is applicable to this case."

23. On April 9, 1999, over a year after the initial claim was submitted, Washington National paid the claim.

24. On April 16, 1999 the Bureau of Insurance wrote to Washington National, again requesting documentation previously requested.

"Please provide a copy of the initial denial letter and subsequent letter &/or notice(s) sent to [Consumer] regarding your company's decision on this claim. The only letter, in our file, sent to [Consumer] regarding your company's decision on her claim, is dated February 16, 1999. This appears to be the decision by your company on her appeal."

25. On April *30, 1999, Washington National wrote:*

"Please be advised that our correspondence to [Consumer] regarding her claim for orthotics were done on the Explanation of Benefits forms. Our original consideration was done on April 22, 1998, and the examiner utilized the incorrect remark code "A#" which states "information requested has not been received". The examiner should have utilized requested a copy of the bill which included the diagnosis. On December 7, 1998, the orthotic's claim was denied. We have enclosed copies of the Explanation of Benefits forms."

CONCLUSIONS

26. As set forth in paragraphs 11, 12, and 13, Washington National violated Rule 850(8)(E)(5) by sending Consumer an adverse determination notice which failed to include the principal reasons for the determination, the instructions for initiating an appeal for reconsideration of the determination, the instructions for requesting a written statement of the clinical rational for the determination, and a phone number to call for information on and assistance with initiating an appeal for reconsideration and/or requesting clinical rational and review criteria.

27. As set forth in paragraphs 14, 15, 19, 21, 22, 24, and 25, Washington National violated Title 24-A M.R.S.A. §220(2) by failing to fully and timely fulfill its legal obligation to provide the Bureau of Insurance with all documents related to Consumer's claim.

28. As set forth in paragraphs 15, 16, 17, and 18, Washington National violated Rule 850(8)(D)(2) by failing to by failing to have a clinical peer evaluate the clinical appropriateness of the adverse determination.

COVENANTS

29. A formal hearing in this matter is waived and no appeal will be made.

30. At the time of executing this Agreement, Washington National will pay to the Maine Bureau of Insurance a penalty in the amount of ten thousand dollars ($10.000), payable to the Treasurer of the State of Maine.

31. In consideration of Washington National's execution of and compliance with the terms of this Consent Agreement, the Superintendent agrees to forgo pursuing any disciplinary measures or other civil sanction for the specific violations described above other than those agreed to in this Consent Agreement.

MISCELLANEOUS

32. This Consent Agreement may only be modified by the written consent of the parties.

33. It is understood by the parties to this Agreement that nothing herein shall affect any rights or interests that any person not a party to this Agreement may possess.

34. Washington National acknowledges that this Consent Agreement is a public record within the meaning of 1 M.R.S.A. § 402 and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408.

35. Washington National has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this Agreement.

For: Washington National Life Insurance Company

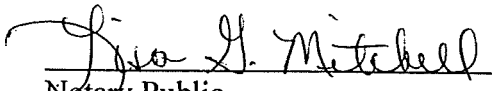
Dated: 11/1, 1999

By: 
Signature

For: Brian Camling
Typed Name

Vice President
Typed Title

Subscribed and sworn to before me
this 1st day of November, 1999.


Notary Public

FOR THE BUREAU OF INSURANCE

Dated: 11/4, 1999

Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, SS.

Subscribed and sworn to before me
this _____ day of _____, 1999.

_____
Notary Public/Attorney-at-Law

FOR THE MAINE ATTORNEY GENERAL

Dated: Nov. 3, 1999

Judith Shaw Chamberlain
Assistant Attorney General

ANGUS S. KING, JR.
GOVERNOR

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ALESSANDRO A. IUPPA
SUPERINTENDENT

IN RE: HEALTHSOURCE MAINE, INC.) **CONSENT AGREEMENT**
) **BUREAU OF INSURANCE**
) **DOC NO. MCINS 99-10**

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among Healthsource Maine, Inc. (hereafter "Healthsource") and the Superintendent of the Maine Bureau of Insurance (hereafter also "the Superintendent"). Its purpose is to resolve, without resort to an adjudicatory proceeding, violations of Bureau of Insurance Rule Chapter 850 as set forth below.

FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations.

2. Healthsouce Maine, Inc has been a Maine licensed HMO, License # HMD 4, since 1987.

3. Consumer filed a formal complaint, complaint # 1998503672, with the Bureau of Insurance on July 17, 1998 challenging their insurer, Healthsource's, denial of coverage for an outpatient surgical procedure.

4. On October 1, 1997 Healthsource wrote to Consumer denying coverage for an outpatient surgical procedure. This letter failed to state the reasons for the denial. The letter stated in relevant part:

> *"I have reviewed the information which has been provided in support of this request. Healthsource is unable to authorize coverage for these service(s) because:*
>
> *Reviewed by Med Director 9/26/97."*

5. Consumer filed two appeals contesting the denial of coverage by Healthsource.

6. Rule 850(9)(C)(1)(b) requires that if a decision in a first level appeal is adverse to the covered person, the written decision shall contain:

   - *The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers).*
   - *A statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.*
   - *The reviewers' decision in clear terms and the basis for the decision. A reference to the evidence or documentation used as the basis for the decision.*
   - *Notice of the covered person's right to contact the Superintendent's office, along with the Bureau's toll free number and address.*
   - *A description of the process to obtain second level grievance review of a decision, the procedures and time frames governing a second level grievance review.*

7. Rule 850(9)(D)(3)(f) requires that if a decision in a second level appeal is adverse to the covered person the adverse decision notice must comply with Rule 850(9)(C)(b)(i-v), and shall contain:

   - *The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers).*
   - *A statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.*
   - *The reviewers' decision in clear terms and the basis for the decision. A reference to the evidence or documentation used as the basis for the decision.*
   - *Notice of the covered person's right to contact the Superintendent's office, along with the Bureau's toll free number and address.*

8. On March 18, 1998, Healthsource sent Consumer an adverse determination notice to his first level appeal. That adverse determination notice failed to include:

   - A statement of the reviewer's understanding of the covered person's grievance and all pertinent facts.
   - Notice of the covered person's right to contact the Superintendents Office.
   - Toll free number and address of the Bureau of Insurance.
   - A statement of the consumers right to a second level grievance review.

9. On May 20, 1999, Healthsource sent Consumer an adverse determination notice which contained the following statement: "Benefits will not be paid for the following. N. Covered Health Services that are not Medically Necessary for the diagnosis and treatment of any accidental injury, sickness or maintenance." The letter failed to

provide any explanation as to why the services were determined not to be medically necessary.

10. The May 20, 1998 adverse determination notice to consumer's second level appeal failed to include:

- The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers).
- A statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.
- The reviewers' decision in clear terms and the basis for the decision.
- A reference to the evidence or documentation used as the basis for the decision.

CONCLUSIONS OF LAW

11. As described in paragraph eight above, Healthsource failed to comply with the requirements of Rule 850(9)(C)(1)(b) in its March 18, 1998 adverse determination notice to Consumer.

12. As described in paragraphs nine and ten above, Healthsource failed to comply with the requirements of Rule 850(9)(C)(1)(b)(i-iv) in its May 20, 1998 adverse determination notice to Consumer.

COVENANTS

1. A formal hearing in this matter is waived and no appeal will be made.

2. At the time of executing this Agreement, Healthsource will pay to the Maine Bureau of Insurance a civil penalty in the amount of two thousand dollars ($2,000), payable to the Treasurer of the State of Maine.

3. In consideration of Healthsource's execution of and compliance with the terms of this Consent Agreement, the Superintendent agrees to forgo pursuing any disciplinary measures or other civil sanction for the actions described above other than those agreed to in this Consent Agreement.

MISCELLANEOUS

15. This Consent Agreement may only be modified by the written consent of the parties.

16. It is understood by the parties to this Agreement that nothing herein shall affect any rights or interests that any person not a party to this Agreement may possess.

17. Healthsource acknowledges that this Consent Agreement is a public record within the meaning of 1 M.R.S.A. § 402 and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408.

18. Healthsource has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this Agreement.

For Healthsource Maine, Inc.

Dated: July, 1999

By: R. M. White
Signature

For: Richard M. White
Typed Name

General Manager
Typed Title

this 22 day of July, 1999.

Barbara J Graham
Notary Public

My Commission expires Sept 26, 2002

FOR THE BUREAU OF INSURANCE

Dated: 8/12, 1999

Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC, SS.

Subscribed and sworn to before me
this 12th day of August 1999.

Martha E. Curtis
Notary Public/Attorney-at-Law

MARTHA E. CURTIS
NOTARY PUBLIC • MAINE
MY COMMISSION EXPIRES JULY 11, 2005

FOR THE MAINE ATTORNEY GENERAL

Dated: July 28, 1999

Judith Shaw Chamberlain
Assistant Attorney General

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ANGUS S. KING, JR.
GOVERNOR

ALESSANDRO A. IUPPA
SUPERINTENDENT

IN RE:
TUFTS HEALTH PLAN
OF NEW ENGLAND, INC.

CONSENT AGREEMENT
Docket No. MCINS 99-07

This document is a Consent Agreement, authorized by 5 M.R.S.A. § 9053(2) entered into by and among Tufts Health Plan of New England, Inc. (hereafter "Tufts") and the Superintendent of the Maine Bureau of Insurance (hereafter also the "Superintendent"). Its purpose is to resolve, without resort to an adjudicatory proceeding, a violation of Bureau of Insurance Rule Chapter 850(8)(E)(5).

FACTS

1. Tufts has been licensed by the State of Maine as an HMO since August 26, 1996.

2. The Superintendent of Insurance is the official charged with administering and enforcing Maine's insurance laws and regulations.

3. Pursuant to Bureau of Insurance Rule Chapter 850(8)(E)(5), a written notice of an adverse utilization review determination must, among other things, include the principal reasons for the determination and the instructions for requesting a written statement of the clinical rationale, including any clinical review criteria used to make the determination.

4. On July 17, 1997, the Superintendent issued Bureau of Insurance Bulletin 265, Utilization Review Determinations. That bulletin advised of the adverse utilization review determination notice requirements of the Health Plan Improvement Act, 24-A M.R.S.A. § 4303(4)(A)(1), and Rule 850(E)(5). Notably, the bulletin advised:

> *It has come to the Bureau's attention that adverse utilization review determinations sometimes fail to communicate any meaningful explanation for the reviewer's conclusion that a requested service is not medically necessary. Examples would include denials on the grounds that the requested services "is not medically*

MISCELLANEOUS

10. Tufts understands and acknowledges that this Agreement will constitute a public record within the meaning of 1 M.R.S.A. § 402, and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408.

11. It is understood by the parties to this Agreement that nothing herein shall affect any rights or interests that any person not a party to this Agreement may possess.

12. This Consent Agreement may only be modified by the written consent of the parties.

13. Tufts has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this Agreement.

FOR TUFTS HEALTH PLAN OF NEW ENGLAND, INC.

Dated: May 24, 1999

By: Jon M Kingsdale
Signature

For: Jon M. Kingsdale
Typed Name

Sr. Vice President, Planning and Development
Typed Title

Subscribed and Sworn to before me

this 24th day of May, 1999.

Karen E. Chase
Notary Public

Appendix F
Consumer Health Care Division Public Speaking Engagements in 1999

March

Division Director, Alice Knapp, a presenter on Rule 850 at a Department of Human Services Quality Oversight Program seminar.

April

Division Director, Alice Knapp, guest lecturer at University of Southern Maine Muskie School of Public Service graduate class on Managed Care.

May

Division Director, Alice Knapp, featured guest for a segment of Central Maine cable TV program "Senior Viewpoint."

Division Director, Alice Knapp, a presenter at the Maine Medical Association's annual "Conference on the Practice."

Division Director, Alice Knapp, featured speaker at Mercy Hospital's annual dinner.

Division Attorney, Norm Stevens, a presenter at a Medicare conference in Augusta.

Division Director, Alice Knapp, addressed the Maine Council of Senior Citizens at their annual meeting

Division Director, Alice Knapp, and Division Nurse, Kathy Crawford, addressed a regional utilization review coordinators meeting at Acadia Hospital in Bangor.

June

Division Director, Alice Knapp, Division Attorney, Norm Stevens and Division Nurse, Kathy Crawford, presented a compliance seminar on the requirements of Bureau Rule Chapter 850 at the Portland Campus of USM.

Division Director, Alice Knapp, guest lecturer for Division Advisory Council Member Kathyrn Pears' St. Joesephs graduate class on Health Care Policy & Politics.

Division Director, Alice Knapp, gave a presentation to the Senior Legislative Advocacy Coalition.

Division Director, Alice Knapp, spoke to Coastal Medical Support in Rockport

July

Division Director, Alice Knapp, Division Attorney, Norm Stevens and Division Nurse, Kathy Crawford, gave a mini Rule 850 compliance seminar to Harvard Pilgrim.

Division Director, Alice Knapp, and Division Nurse, Kathy Crawford, spoke to physicians and administrators at Maine General Hospital in Augusta.

August

Division Director, Alice Knapp, and Bureau Health Policy Analyst, Glenn Griswold, made a presentation to regional hospital chief financial officers and billing representatives at Maine Coast memorial Hospital in Ellsworth.

Division Director, Alice Knapp, and Bureau Health Policy Analyst, Glenn Griswold, made a presentation at a Maine Hospital Association conference in Augusta.

September

Division Nurse, Kathy Crawford, attended Franklin County Health Network's presentation on health insurance in Farmington.

Division Nurse, Kathy Crawford, made a presentation to utilization review and case management staff at Maine General Medical Center.

Division Nurse, Kathy Crawford, participated as a panelist at Franklin County Health Network's presentation on health insurance in Jay.

October

Division Director, Alice Knapp, the featured speaker at a Lewiston breakfast meeting of the Maine Health Underwriters.

Division Director, Alice Knapp, and Bureau of Insurance Deputy Superintendent, Nancy Johnson, were presenters at a Life and Health Underwriters continuing education seminar in Lewiston.

November

Division Director, Alice Knapp, taped a segment of "Focus on Franklin County" on WKTJ in Farmington.

December

Division Director, Alice Knapp, spoke to a group of local school superintendents in Augusta.

Division Director, Alice Knapp, attended the Legislative Joint Standing Committee on Banking and Insurance's Public Hearings on carryover patient protection bills in Biddeford, Lewiston and Bangor.

Division Director, Alice Knapp, a panelist at a Health Care Forum in Winslow sponsored by State Representative Zack Matthews

Consumer Health Care Division
Advisory Council
Minutes of February 22, 1999 Meeting

Meeting Attendees: Representative Jane Saxl, Susan Dore, John Marvin, Bob Philbrook, Christina Valar Breen, Chris Zukas-Lessard, Kathryn Pears, Alice Knapp, Norman Stevens

Alice gave an update on Division staffing and introduced Norman Stevens, who has been hired as the Division Staff Attorney.

Alice presented the Division Work Plan, noting that the plan is a work in progress. Jane suggested the Division consider a program of volunteer complaint handlers trained and administered by the Bureau.

Discussion of outreach activities. Alice showed the Bureau of Insurance public service announcement produced by the National Association of Insurance Commissioners. The PSA has been sent to Maine television statements along with a cover memo from the Superintendent. Council members did not particularly care for the PSA and discussed options for creating new and better PSAs. Council members expressed interest in assisting with the development of improved PSA scripts. Alice noted the state-of-the art production equipment available at the University of Maine at Augusta, and will investigate opportunities for working with University students and/or staff to produce PSAs. John noted there may be foundation money available to develop or run PSAs. Jane suggested the Division establish key contacts at local television stations, as developing a relationship with personnel at the stations is invaluable to getting air play for PSAs. Susan noted that NAMI members take NAMI PSAs to TV stations, and that a similar volunteer effort could assist in promoting PSA air play.

Alice made a presentation of Bureau of Insurance Rule Chapter 850 highlights.

Council members asked about the Bureau's role with regard to pending legislation, and expressed their desire that the Bureau and Consumer Health Care Division take proactive, pro-consumer advocacy positions on pending health bills. Alice pointed out that the Bureau's role as part of the Administration is to administer the insurance laws the Legislature sees fit to enact rather than to establish policy. The Bureau's role when it comes to policy is primarily to serve as a resource for policy makers. The Bureau does identify problems it encounters in the course of enforcing the Insurance Code, and proactively promotes legislation and rulemaking when it determines additional tools are required to effectuate policy reflected in the current regulatory scheme. Alice cited the development of Bureau Rule 850, Health Plan Accountability, and the Bureau's support for laws authorizing Bureau publication of complaint ratios and

strengthening of the Code's Unfair Claims Practices provision as recent examples of the Bureau's consumer protection proactivity. Christina Valar further discussed the Department of Professional & Financial Regulation's role in the legislative process and said she is available to discuss the Department's position on pending legislation.

Council members will come to the next meeting prepared to discuss problems they and their membership or constituents perceive or are experiencing with their health plans.

The Council is interested in continuing to meet monthly at present. The next Council meeting date was set for March 29th.

Consumer Health Care Division
Advisory Council
Minutes of March 29, 1999 Meeting

Meeting Attendees: Representative Jane Saxl, John Marvin, Bob Philbrook, Bob Goldman, Nancy Johnson, Chris Zukas-Lessard, Kathryn Pears, Alice Knapp, Katy Longley

The February 29th meeting minutes looked fine to all present.

Glenn Griswold made a presentation on how he reviews provider networks for adequacy. Bob Goldman asked that hardcopies of the slide presentation be made available to the Council. Alice Knapp noted that, consistent with the exceptions provisions in Rule 850, plans are permitted to have network holes where they are finding it difficult to contract with providers, but that where a hole exists due to contracting difficulties with locally available providers, consumers must have access to local providers at no additional expense and cannot be required to travel long distances to access a network provider.

Discussion of Council purposes. Bob Philbrook asked if council members, in the course of their advocacy functions, can represent a position as a Council position. All agreed that while a Council member is free to identify themselves as a member of the Council, it is not appropriate for them to represent their position as a Council position if the Council has not formally taken a position on a particular issue. The Council's role is that of an advisory group to the Division, and Council members are free to advocate for a particular issue before the Council, but the Council's function is not that of an advocacy group. John Marvin gave an example of recent testimony he provided before the Legislature in which he stated his position is one endorsed by several Council members, but does not represent the position of the Council.

Jane Saxl asked Alice Knapp what she needs from the Council, and Alice replied she needs ideas, access to Council member constituents and assistance in getting information to consumers. Kathryn Pears asked if the Bureau has any sense of how many consumers are not complaining to the Bureau. Alice said the Bureau assumes many consumers do not contact the Bureau either because they don't know we are here or don't have the time, skills, or inclination to pursue a complaint. Accordingly, the Bureau is committed to ensuring that the complaints we do handle are rigorously investigated, and problems encountered with plans are addressed. Sometimes we simply ask plans how they plan to ensure a similar problem doesn't reoccur, and other times we initiate disciplinary proceedings. Additionally, the Consumer Health Care Division has as one of its goals to reach consumers and make them aware of the Bureau's services.

Jane asked about any progress made on consumer outreach. Alice noted she applied for a summer intern specializing in public relations/media/desk top publishing, and that the Division work plan includes the development of a media plan. Katy mentioned the Department is sponsoring a media training for employees on April 30th.

Bob Goldman suggested a flyer be included in every mailing (I need help fleshing this one out). Chris Zukas Lessard suggested informational brochures be made available to employers for distribution to employees at the time of plan decisionmaking to help them make sound choice. Katy mentioned Minnesota as an example of a state where employers were focussing on obtaining meaningful plan information to drive plan election.

John Marvin suggested where employers change plans, the old carrier be required to provide information to the new carrier necessary to ensure a seamless transfer such as outstanding referrals and ongoing treatment plans. Bob Goldman described an annual deductible crediting problem he ran into when his coverage changed from Blue Cross to Healthsource, and also discussed problems his wife experienced when his wife accepted a plan driven drug substitution. Bob Philbrook then discussed a problem his son is experiencing with obtaining approval for a full spinal MRI.

The Council requested a presentation on the Bureau's complaint handling process at our next meeting, which was scheduled for April 27th from 1-3pm.

Memorandum

To: *Representative Jane Saxl, Senator Lloyd LaFountain, Katy Longley, Bob Goldman, Kathryn Pears, Kim Wallace,Susan Dore, John Marvin, Bob Philbrook, Chris Zukas-Lessard, Nancy Johnson*
From: *Alice Knapp, Director, Consumer Health Care Division*
cc: *Alessandro Iuppa*
Date: *Thursday, April 22, 1999*
Subject: *Advisory Council Meeting Agenda*

As discussed at our March 29, 1999 meeting, the next Consumer Health Care Division Advisory Council Meeting is scheduled for Tuesday, April 27, 1999, from 1:00-3:00 PM at the Department Of Professional & Financial Regulation in the Androscoggin Room.

AGENDA

1. Review of March 29, 1999 minutes

2. Update on Division staffing - introduction to the Division's new nurse, Kathy Crawford

3. Presentation on consumer complaint handling process and how existing Life & Health Division complaint handling integrates with the new Division

4. Rule 850 target areas for enforcement

5. Outreach Activities

6. Council Member issues

Memo

To: Consumer Health Care Division Advisory Council - Representative Jane Saxi, Senator Lloyd LaFountain, III, Commissioner S. Catherine Longley, Christine Zukas-Lessard, Kathryn Pears, Robert Philbrook, Robert Goldman, Susan Dore, John Marvin, Kim Wallace, Nancy Johnson

From: Alice Knapp, Director, Consumer Health Care Division

CC: Alessandro luppa, Superintendent of Insurance

Date: 06/16199

Re: Update on Division Activities and Meeting Schedule

I consulted on our meeting schedule with Jane and she suggested we take the summer off and meet again in September. In the interim, I will provide monthly updates on the Division's activities. Should any Council member wish to meet before September, please let me and Jane know and we will try to find a time that accommodates council members' summer schedules. Also, please forward any items you would like to add to a meeting agenda to Jane's and my attention.

At our April 27th meeting I introduced the Division's new nurse, Kathy Crawford and introduced Bureau Life & Health Division complaint staff. We reviewed the Bureau's complaint handling process, and I discussed Rule 850 target areas for enforcement.

I have enclosed a copy of a letter that went out to our Maine licensed HMOs (Aetna/NYLCare, Cigna/Healthsource, Tufts Health Plan of New England, Harvard Pilgrim, Blue Cross, Maine Partners and Central Maine Partners) last week discussing our new complaint handling approach and our targeted enforcement initiative. The letter also invites the plans to a compliance seminar that we are hosting next Wednesday, June 23rd, 8:30am-12pm at the University of Southern Maine, Portland campus. Jane suggested Advisory Council Members might be interested in attending as well. Feel free to attend if you are interested, and give me a call if you need a USM parking permit.

May was a very busy month for the Division. I worked with our attorney, Norm Stevens, who has now begun drafting consent agreements as part of our targeted enforcement initiative. Four consent agreements have now been mailed to three different companies and more are in the pipeline. Consent agreements become public documents once they are **finally** executed and will be shared with the Council and reported in the Bureau newsletter.

Our nurse Kathy Crawford has jumped right into analyzing complex complaint referrals and has begun meeting with medical directors and utilization review staff at our local plans to introduce herself and familiarize herself with their processes. We are finding her clinical expertise to be an invaluable addition to our internal capabilities.

Staff from both the Consumer Health Care and Life & Health Divisions has met recently on complaint and Division issues with Blue Cross, Tufts and Healthsource. Staff ftom both Divisions will also be spending a day with Bureau of Medical Services staff on June 15th for an issues and brainstorming session that will kick off our development of a health plan reporting rule under the HMO and Health Plan Improvement Acts.

I have been doing a good deal of public speaking this past month. In May I spoke about the Division and our activities at the Maine Medical Association's Annual Conference on the Practice, at Mercy Hospital's Annual Banquet and at the Maine Council of Senior Citizens Annual Meeting. I was the guest speaker on an episode of "Senior Viewpoint," a Frontier Vision public access cable TV program that has been hosted by Rose Rogan Dinsmore for nine years. I took Kathy Crawford with me to Acadia Hospital and spoke to a group of some 40 Northern Maine hospital utilization management personnel. So far this month I have spoken at a Senior Legislative Advocacy Coalition meeting, will be guest lecturing at Kathryn Pears' graduate class in Health Care Policy & Politics and will be speaking to Coastal Medical Support in Rockland, a group of medical-related personnel in the midcoast area that was formed to bring educational opportunities to that area.

The Division's intern, a USM sophomore, came on board at the beginning of this month and has been busy analyzing consumer outreach brochures from Maine and other states for readability and effectiveness. He is currently reviewing and editing the Bureau's draft Health Insurance Complaint Ratios brochure, and will be helping me pull together a slicker overhead presentation for my public speaking engagements. He will also be designing a refrigerator magnet with the Bureau's Consumer Helpline 800 # and will be tackling the State Agency resource guide an Advisory Council member suggested some meetings back.

The Division is excited and energized and functioning as a team both within the unit and as a broader team working closely and meeting weekly with the Bureau's Life & Health Division complaint staff. We're also all extremely busy and I am doing what I can to help staff effectively manage their workloads and prioritize when something has to give.

I hope you are all having a wonderful summer and look forward to working with you in the months ahead. I am delighted that Advisory Council members are responsible for many of my recent speaking engagements and appreciate your support and enthusiasm.

Memo

To: Consumer Health Care Division Advisory Council – Representative Jane Saxl, Senator Lloyd LaFountain III, Commissioner S. Catherine Longley, Christine Zukas-Lessard, Kathryn Pears, Robert Philbrook, Robert Goldman, Susan Dore, John Marvin, Kim Wallace, Nancy Johnson

From: Alice Knapp, Director, Consumer Health Care Division

CC: Alessandro Iuppa, Superintendent of Insurance

Date: 08/12/99

Re: Update on Division Activities

I hope you are all having a lovely summer. Things continue busy here at the Bureau and in the Consumer Health Care Division. Our Rule 850 compliance seminar in Portland June 23rd went well, and we were pleased that Advisory Council members John Marvin, Bob Goldman and Bob Philbrook were able to attend. All our licensed HMOs attended, except Harvard Pilgrim, whose invitation arrived while the addressee was on vacation. We subsequently hosted a mini seminar for Harvard here at the Bureau.

Division Staff Attorney Norm Stevens has been diligently working on Rule 850 violation enforcement referrals, and a number of consent agreements are in the mail. I have enclosed a copy of our first, finalized Rule 850 violation consent agreement for your information. Our enforcement work has raised an interesting issue. Two of our HMOs are suggesting that their general practitioner medical directors qualify as "clinical peers" on appeal panels as they: a) are administering clinical criteria developed by clinical peers; and, b) have "demonstrable expertise to review a case" per Rule 850's definition of "clinical peer," as they are trained to review and apply clinical review criteria. The Bureau disagrees with this interpretation of Rule 850's requirement that clinical peers review adverse utilization review appeals. Norm has written to the Maine Boards of Medicine and Dentistry seeking their opinion on a Medical Director's competence to review the condition at issue in one of the files that first raised the issue.

Norm has also begun work on a rule to define the "basic health care services" that must be covered by HMOs. This effort responds to the enactment last session of P.L. 222, which rejected Rule 750's Basic HMO Plan as the minimum benefits threshold for HMO health plans.

Division nurse Kathy Crawford has, to date, had 27 complaint files referred to her for review from our Life & Health Division complaint staff. Kathy's file review has her regularly on the phone with consumers, health providers and health plan utilization reviewers. She accompanied me to speak to a group of doctors and administrators at Maine General Hospital last month, and has been meeting with Maine based utilization review personnel and appeal coordinators. Kathy has met with Tufts Medical Director Lisa Letoumeau and staff at Katahdin, which performs utilization review and case management for Blue Cross. Next week she is scheduled to meet with Healthsource, Greenspring (Blue Cross' mental and behavioral health network administrator) and a Harvard Pilgrim Medical Director.

The Division has been quite fortunate to have a USM student summer intern working with us this summer. Our intern, Dan Harrington, has been enormously helpful on a number of projects, including our development of a refrigerator magnet to help publicize the Bureau's existence and 800#. I have enclosed a picture of what the magnet will look like, and it is in the process of being put out to bid by State Purchasing. Also currently out to bid are the Bureau's first Complaint Ratio brochures, the development of which required the participation of staff from several Bureau divisions.

Dan has created a binder of transparencies for the Consumer Health Care Division's use in making Health Plan Improvement Act and Rule 850 presentations. He has also been working with us to format an improved health insurance complaint form and to develop various charts to track our efforts to date. For example, Kathy is tracking the complaint referrals she receives by chronology, issue and company. This tool will help us analyze our work flow and the issues we are addressing, with the objective of determining whether or not our efforts have been effective in improving plan performance and consumer experience with their plans.

We have begun running reports from our complaint database and current numbers indicate our health insurance complaint volume is up close to 30% over last year. While we expect that publicizing our availability to assist consumers will lead to further increases in complaint volume, our long-term objective is to bring those numbers down through a combination of consumer education and regulatory oversight to ensure carrier compliance with Maine requirements. The challenge in the interim will be to ensure we have adequate resources to address the complaints received.

The Bureau also continues to participate on the DHS/DPFR Interagency Task Force on HMO oversight. As some of you know, the HMO Council is none too pleased with DHS' Draft Rule Chapter 109, Quality Oversight For Commercial HMOs, and continues to argue that primary jurisdiction for HMO regulation should lie solely with the Bureau of Insurance. Kathy and I attended a DHS sponsored IATF training on DHS' proposed quality oversight program. Attendee feedback indicates DHS staff were particularly interested in the sample, redacted complaint files Kathy and I provided and discussed.

I have enclosed some articles I thought might be of interest, and appreciate the articles forwarded to me by various Advisory Council Members. Please continue to stay in touch and pass along your ideas. I will touch base with Jane in September to discuss scheduling our next meeting. Please contact either Jane or myself if you have issues you would like to see on the agenda.

Consumer Health Care Division
Advisory Council
Minutes of November 22, 1999 Meeting

Meeting Attendees: Superintendent of Insurance Alessandro Iuppa, John Marvin, Bob Philbrook, Bob Goldman, Representative Jane Saxl (arrived at 2:30pm)

Alice gave an update on Division activities:

1) Six Rule 850 violation consent agreements have been finalized since the beginning of the year and two more are due in shortly. Copies of consent agreements were distributed to participants.

2) Outreach efforts continue with invitations continuing to roll in for speaking engagements to diverse groups ranging from advocacy organizations to providers and insurance agents. We purchased 5000 refrigerator magnets that provide the Bureau's 800#, website and address. We are sending them out with complaint forms and distributing them at all speaking engagements. Jane thinks the magnet has too much information on it and that sending them to persons requesting a complaint form reaches people who are already aware of the Bureaus existence. The suggestion was made to distribute magnets to pharmacies.

3) Alice gave a heads up that the Bureau is working on a draft HMO "basic health care services" rule in response to P.L. Chapter 222 enacted last year. While HMOs initially promised comprehensive benefits as disease prevention and early diagnosis are key to long-term cost containment, price competition in the market and escalating medical costs have led to a steady erosion of benefits. HMOs are required by law to provide "basic health care services," defined by the law to mean those services "that an enrolled population might reasonably require in order to be maintained in good health [including] at a minimum, emergency care, inpatient hospital care, inpatient physician services, outpatient physician services, ancillary services such as x-ray services and laboratory services and all benefits mandated by statute and mandated by rule applicable to HMOs." Rule 850 established the requirements of the HMO Basic Plan, defined by Bureau Rule 750, as the floor for HMO health plan benefits. P.L. 222, supported by the HMOs, expressly rejects Rule 750 standardized plans as a benefits floor, overriding Rule 850.

4) Health complaint volumes continue to rise. Complaints are up 42% over 1998 and up 68% from 1997. We received a Bureau record of 134 health complaints in October. The lowest number of complaints opened in any month in 1999 was 73. For the sake of comparison, the highest number of health complaints recorded in any month in 1998 was 85 and the lowest number was

45. The highest number of health complaints in any month in 1997 was 76, and the lowest number was 45.

5) The Tufts withdrawal particularly harms Medicare eligible individual policyholders who had guaranteed renewability rights but do not have guaranteed issue rights. Persons who purchased individual coverage prior to Medicare eligibility and elect to retain their private coverage once Medicare eligible tend to be people with catastrophic prescription drug needs such as transplant recipients whose anti-rejection medications cost some $18,000 a year. Medicare provides little or no prescription drug benefit, and the maximum benefit available under Medicare Supplement Plan J is $3,000. Unfortunately, there are in excess of 70 current Tufts policyholders who fall into this category.

Al discussed the Anthem transaction procedurally and distributed the Bureau's Notice of Hearing, which describes the transaction review standards. John asked if the standards can't be boiled down to facilitate consumer understanding of what the issues are in a nutshell. John was pleased by Al's assurance that the Bureau will issue press releases around the dates of the January public hearings, which will summarize the issues to be considered. Al discussed Bureau staffing on the Anthem proceeding and noted he has retained outside counsel from Philadelphia. The Bureau is using the same firm that was involved with the charitable conversion issue before the legislature when that issue was being hotly debated.

Bob Goldman asked about Blue Cross' traditional role as the carrier of last resort. Alice pointed out that Maine's community rating laws with their guaranteed issue requirements in the individual and small group markets relieved BC of that obligation. The group then discussed how the current access problem lies with the exorbitant cost of coverage. Al distributed a report showing the most recent quarterly results for Maine's licensed HMOs. All except the BC Partners plans are reporting losses. Bob emphasized the continuing profitability of the big plans nationally and warned that with the continuing consolidation of plans, the market is not as competitive as we might like to think.