MAINE DEPARTMENT OF
Professional & Financial Regulation

Bureau of Insurance Consumer Health Care Division Annual Report to the Legislature for the Year 2001

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Angus S. King, Jr.
Governor

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Commissioner

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I. Overview

This report is being issued pursuant to 24-A M.R.S.A. C. §4321(J). The Consumer Health Care Division (CHCD) is one of several work units in the Maine Bureau of Insurance (the Bureau) which is within the Department of Professional and Financial Regulation (PFR). During its third year of operation, CHCD focused it efforts on consumer assistance, outreach, and oversight of insurer compliance with statutory and regulatory issues important to Maine consumers.

The Division consists of ten employees. The Director was newly hired in March. Staff resources include four Insurance Analysts, two Assistant Insurance Analysts, a Nurse, an Attorney, and the Policy Development Specialist newly hired in July.

One of the Insurance Analysts is responsible for the review and approval of health insurance forms, and three Insurance Analysts are responsible for the investigation and resolution of consumer health insurance complaints. In some instances, the volume of consumer complaints necessitates the reassignment of the form approval analyst to complaint investigation. The Staff Attorney oversees the implementation of the Bureau's external review process, drafts and reviews rules, and brings enforcement actions against carriers when violations occur. The Policy Development Specialist reviews managed care plans for compliance with provider network adequacy measures, assists in the drafting of regulations for preferred provider arrangements, develops educational materials, and drafts reports on studies and issues involving health policy. The two Assistant Insurance Analysts have been invaluable as the division establishes systems for tracking, trending, and analyzing data. One of the Assistant Insurance Analysts is responsible for answering consumer calls a large percentage of the time. The other Assistant Insurance Analyst is responsible for entering consumer complaint data into the complaint database and producing correspondence to allow the Insurance Analysts to conduct a formal investigation into the complaint. The Nurse consultant reviews complex complaints that include determinations of medically necessary care and complex health questions, licenses Utilization Review Entities, conducts outreach, and is one of the survey team members of the Interagency Task Force for the Quality Oversight of Commercial Health Maintenance Organizations (HMOs).

II. Accomplishments

A. Consumer Assistance

- **Inquiries and Outreach**

CHCD staff responded to 6,824 calls during 2001. Calls, like written complaints, cover a variety of queries on health insurance issues. Typical questions include: *"I just lost my job. Am I entitled to COBRA?"*; *"I don't know which Medicare Supplement policy to buy.''*; and "*Why did the Bureau approve this rate increase for my insurance company?"* Staff is often immediately able to assist callers by providing verbal information, referring callers to the Bureau's web site (www.MaineInsuranceReg.org), and/or mailing issue-related brochures.

The CHCD responded to numerous calls from seniors and their families seeking Medicare supplement coverage. Many callers were concerned about the absence of prescription drug coverage in traditional Medicare supplement policies. The division attorney consulted regularly with the Bureau of Elder and Adult Services (BEAS) in the Department of Human Services, Legal Services for the Elderly and the

Centers for Medicaid and Medicare (CMS) to coordinate the Bureau's efforts and ensure dissemination of accurate information to consumers. Hundreds of copies of the Bureau's *Consumer's Guide to Medicare Supplement Insurance* were distributed.

The CHCD staff responds to request for assistance and information from state and federal legislative officials. Inquiries from federal officials present unique questions of jurisdiction due to the plethora of federal regulations, including ERISA that preempt state health insurance law. The CHCD staff met with representatives of the U.S. Department of Labor, Pension and Welfare Office to obtain information on COBRA, ERISA, and HIPAA to allow the CHCD staff to provide information that is more accurate to consumers.

Division staff participated in several public speaking events this year. Consumers, providers, producers, and carriers all requested presentations. One of the objectives of the CHCD is to educate consumers about how to advocate for themselves so they feel comfortable with the system and is aware of their rights. The CHCD continues to encourage communication between carriers and providers during presentations to these groups. The CHCD staff organized and implemented a long-term care seminar in Bangor and Portland for over 150 producers. Additionally, the CHCD staff organized a presentation on insurance issues for a delegation of health care providers and administrators from the Republic of Moldavia. The Republic of Moldavia sought guidance in developing a healthcare and insurance system and appreciated the input and information on the experiences of the State of Maine provided by CHCD staff and Commissioner Longley. The CHCD staff visited Anthem Blue Cross/Blue Shield and CIGNA health carrier offices to review their operations and to discuss outstanding issues discovered through the complaint investigation process. Maintaining open communications and developing better understanding of the operations of regulated entities is beneficial in the conduct of the Division.

- **Complaints**

During 2001, the CHCD responded to 710 written health insurance complaints filed by health plan enrollees, policyholders, insurance producers, and health care providers. The complaints concerned health insurance carriers, utilization review entities, and third party administrators. The Consumer Health Care Division received complaints by mail, facsimile, and via the Bureau's homepage at www.MaineInsuranceReg.org. Enrollee and policyholder complaints most often concern a carrier's denial of a claim or a service.

Complaint investigation is time consuming, as issues related to health care and insurance coverage are often complex. The statutory timeframes for the exchange of information between the carriers and Bureau staff may result in several months of staff involvement before a consumer complaint is resolved. Emergencies are dealt with immediately and more routine complaints are handled in short order.

It is not uncommon for consumers to request immediate Bureau intervention when carriers deny services perceived as urgent by consumers and their providers. These situations generally occur when a consumer or provider is upset because a carrier has denied a surgical procedure or an inpatient stay. Bureau staff has been able to resolve some of those situations immediately, if it is evident the carrier's denial is flawed or based on specific requirements in the consumer's insurance contract or in Maine law. For example, if Maine law requires equal coverage for medical and mental health diagnoses, carriers may not arbitrarily limit inpatient stays for mental health treatment unless the same restriction applies to medical diagnoses. Staff will require the carrier to initiate an expedited appeal on the member's behalf. There are instances,

however, when Bureau staff also find it necessary to explain to enrollees the basis and/or rationale for the carrier's decision.

CHCD staff was instrumental in assisting with the recovery of $680,849 for enrollees and policyholders in 2001. Most often, the recovered funds are from previously denied claims. Frequently the staff is able to assist consumers in achieving their desired result, however, there are instances where the Bureau is unable to assist the enrollee or policyholders to their satisfaction. Generally, such situations include situations where the carrier is appropriately administering contract exclusions or the carrier may be exempt from state regulation due to federal law. However, even in those situations where federal law takes precedent, staff takes the opportunity for consumer education regarding insurance law, their rights and responsibilities, and the terms of their coverage.

Among its other responsibilities, the Division determines which complaints should be substantiated, as required by law and by Bureau Rule 890 (Rule 890 can be found on line at: http://www.state.me.us/sos/cec/rcn/apa/02/chaps02.htm.) The substantiated complaint statistics for 2000 were released in August of 2001 and are shown below:

A Complaint Index of 1 is average, less than 1 is better than average, greater than 1 is worse than average.

INDIVIDUAL AND GROUP HEALTH Group Name (see note below chart)	Complaint Index 2000	Complaint Index 1999	Written Premium in Maine in 2000	Valid Complaints for 2000
DELTA DENTAL PLAN OF MAINE	**0.0**	**0.0**	$29,661,603	0
UNUMPROVIDENT CORP GROUP	**0.1**	**0.3**	$43,571,170	1
ANTHEM INSURANCE COMPANY GROUP	**0.2**	**0.5**	$497,567,977	21
PRINCIPAL FINANCIAL GROUP	**0.3**	**0.0**	$18,338,211	1
UNITED HEALTHCARE INSURANCE GROUP	**0.8**	**1.0**	$36,590,259	6
AETNA GROUP	**1.3**	**1.6**	$165,408,311	46
CIGNA HEALTH GROUP	**1.5**	**1.2**	$169,125,314	51
CONSECO GROUP	**2.9**	**6.9**	$28,331,874	17
UNITED GROUP OF CO	**3.8**	**Not Available**	$6,413,058	5
HARVARD COMMUNITY HEALTH PLAN GROUP	**5.5**	**0.9**	$64,738,604	74
FORTIS GROUP	**6.0**	**Not Available**	$4,838,704	6
GREAT WEST LIFE ASSURANCE GROUP	**7.1**	**Not Available**	$5,466,153	8
Subtotals			$1,070,051,238	236
Total - Individual and Group Health			**$1,215,402,924**	**252**

AETNA GROUP

AETNA LIFE INS & ANNUITY CO
AETNA LIFE INS CO
AETNA US HEALTHCARE INC

ANTHEM INSURANCE CO GROUP

ANTHEM HEALTH PLANS OF MAINE INC
CENTRAL MAINE PARTNERS HEALTH PLAN
MAINE PARTNERS HEALTH PLAN

CIGNA HEALTH GROUP

CIGNA HEALTHCARE OF MAINE INC
CONNECTICUT GENERAL LIFE INS CO
LIFE INS CO OF NORTH AMERICA

CONSECO GROUP

BANKERS LIFE & CASUALTY CO
CONSECO ANNUITY ASSURANCE CO
CONSECO DIRECT LIFE INS CO
CONSECO HEALTH INS CO
CONSECO LIFE INSURANCE CO
CONSECO MEDICAL INS CO
CONSECO SENIOR HEALTH INS CO
CONSECO VARIABLE INS CO
PIONEER LIFE INS CO
WASHINGTON NATIONAL INS CO

FORTIS GROUP

AMERICAN BANKERS INS CO OF FL
AMERICAN BANKERS LIFE ASSUR CO OF FL
AMERICAN RELIABLE INS CO
FORTIS BENEFITS INS CO
FORTIS INSURANCE CO
JOHN ALDEN LIFE INS CO

GREAT WEST LIFE ASSURANCE GROUP

ALTA HEALTH & LIFE INS CO
GREAT WEST LIFE & ANNUITY INS CO
GREAT WEST LIFE ASSUR CO

HARVARD COMMUNITY HEALTH PLAN GROUP

HARVARD PILGRIM HEALTH CARE INC

PRINCIPAL FINANCIAL GROUP

PRINCIPAL LIFE INSURANCE COMPANY

UNITED GROUP OF CO

CHESAPEAKE LIFE INS CO
MEGA LIFE & HEALTH INS CO

UNITED HEALTHCARE INSURANCE GROUP

UNITED HEALTHCARE INSURANCE COMPANY

UNUMPROVIDENT CORP GROUP

COLONIAL LIFE & ACCIDENT INS CO
PAUL REVERE LIFE INS CO
PROVIDENT LIFE & ACCIDENT INS CO
UNUM LIFE INS CO OF AMERICA

Some complaints are closed but are not substantiated, because staff is unable to devote the time to complete a formal substantiation of the complaint. Legislative Document 428 (PL 2001 c. 165) enacted this past legislative session eliminates the need to substantiate consumer complaints. Because PL 2001 c. 165 became effective September 21, 2001, a decision was made to continue to substantiate complaints until end of calendar year 2001 to allow for equivalent comparisons of complaint ratios from 1999 - 2001. PL 2001 c. 165 defines consumer complaint as "... any written complaint that results in the need for the Bureau to conduct further investigation or to communicate in writing with a regulated entity for a response or resolution to the complaint. Additionally, PL 2001 c. 165 increased the penalty amount the Superintendent may assess against corporations or other entities for violations of insurance laws or regulations from $2,000 per violation to $10,000.

The CHCD staff executed four consent agreements in 2001. The consents were issued for carrier violations of usual, customary and reasonable determinations; failure to appropriately review inpatient services; failure to properly investigate behavioral health services; and violations of the preferred provider arrangement payment differential. The violations concern a consumer's right to participate in planning their health care and understanding the basis for any denial made by their health plan. The consent agreements are posted on the Bureau of Insurance webpage.

B. External Review

Since August 11, 2000, Maine consumers had the right to request an external review when a health insurance carrier or HMO denies benefits for health care services. The law gives consumers the right to request an external review of certain kinds of health care treatment denials, including denials based on issues of medical necessity.

This year the Bureau initiated a bidding process to contract with accredited independent external review organizations (IRO's). The Bureau selected two independent external review organizations, The Center for Health Dispute Resolution, and IPRO.

The Bureau received thirty-two requests for external review that qualified under the statute. Twelve of the cases referred to external review upheld the carrier's initial determination. Four cases resulted in the carrier's decision being reversed. In eight cases, the carrier reversed its decision after the case was sent to the external review organization but before the external review hearing. In one case, the carrier reversed its decision after a request for external review had been received because the cost of the disputed claim was less than the cost of the external review. Seven cases referred to external review are still pending. Finally, in one case, the enrollee withdrew the request for the external review before the review was completed.

CHCD also received requests for external review that did not qualify under the statute, either because the consumer had not exhausted both levels of the insurance carrier's internal appeal process, or because the denials were based on coverage issues rather than medical issues.

The Bureau estimates it will receive 20 requests for external review annually. The Consumer Health Care Division has prepared an informational brochure called *Guide to Requesting an Independent External Review,* which is available on the Bureau's web site at www.MaineInsuranceReg.org under *consumer info*.

C. Licensing Activity

Title 24-A M.R.S.A. §2771 states "*a person, partnership or corporation, other than an insurer, nonprofit service organization, health maintenance organization, preferred provider organization or employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, third-party administrators, health maintenance organizations, preferred provider organizations or employers shall apply for licensure by the Bureau.*" Medical utilization review (UR or MUR) services are defined as "...the processes used to review the use, appropriateness or quality of medical services provided to a person whose medical services are paid for, partially or entirely, by that insurer, nonprofit service organization, third-party administrator, health maintenance organization, preferred provider organization, or employer."

Currently, there are seventy-seven (77) Medical Utilization Review Entities (UREs) licensed in Maine. The CHCD's Nurse Consultant reviewed the applications of eight (8) organizations requesting licensure during 2001. Applicants must certify compliance with Maine's UR requirements and licenses are issued based on the company's representation of compliance with all applicable standards. All of the applications were approved. A list of Maine licensed UREs can be found on the Bureau's web site under *Licensing/Registration.*

The CHCD policy development specialist reviews and registers preferred provider arrangements. Currently there are nineteen registered preferred provider arrangements. The preferred provider arrangement typically includes a provider network that may be used by a number of insurance carriers. The preferred provider arrangement can be the provider network for several self-funded health plans as well as for a fully insured health plan. Preferred provider arrangements are reviewed for compliance with accessibility, utilization, complaint and grievance, contractual, and payment differential requirements under Maine law.

The CHCD staff also reviews HMO provider networks to determine if they comply with the accessibility standards set forth in statute and regulations. The CHCD staff reviews HMO applications to expand their geographic service area to determine if an adequate network of providers is available to render medical services to enrollees. The staff are often involved in discussions when contractual relationships between the insurance carrier and the provider community dissolve, creating the possibility that enrollees may not have access to a participating provider. CHCD staff monitors the situation to assure that enrollees are provided adequate notice and opportunity to find an alternative provider and to make sure that continuity of care for enrollees currently receiving medical services is addressed by the carrier.

D. HMO Quality Oversight

Maine's Insurance Code assigns regulatory oversight of commercial HMOs operating in Maine to the Department of Professional and Financial Regulation, Bureau of Insurance and to the Department of Human Services (DHS). In August 1998, the Departments signed a memorandum of understanding to "clarify their respective areas of responsibility, identify overlapping responsibilities, and establish a cooperative, non-duplicative and efficient regulatory framework for the oversight of commercial HMOs in Maine..."

An Inter-Agency Task Force (IATF) was established by PFR and DHS to perform joint agency functions as required by the memorandum of understanding. The CHCD Director chairs the IATF. Other

members of the task force include DHS's Medical Director and Health Services Supervisor, as well as the CHCD's Nurse Consultant.

Each year, the IATF chair notifies those Maine HMOs that are to be examined that, pursuant to 24-A M.R.S.A. §4215, the Bureau and DHS will conduct a coordinated, on-site state exam related to assessment of quality of health care services. In the interest of minimizing duplication of time and resources, the state examinations are coordinated with each HMO's triennial NCQA accreditation review cycle. NCQA's accreditation program was launched in 1996 to provide employers and the 140 million Americans enrolled in HMOs with information about the quality of those organizations. NCQA evaluates health care in three different ways: through Accreditation (a rigorous on-site review of key clinical and administrative processes), through the Health Plan Employer Data and Information Set (HEDIS -- a tool used to measure performance in key areas like immunization and mammography screening rates), and using a comprehensive member satisfaction survey. Although participation in NCQA's accreditation and certification programs is voluntary, more than half the nation's HMOs currently participate.

A four-member state exam team, under the direction of the IATF conducts the state examinations. The state exam team consisted of:

- Timothy Clifford, M.D., Bureau of Medical Services, Medical Director
- Ellen Austin-Reichtal, R.N., Bureau of Medical Services
- Margaret Ross, R.N., former Director of DHS's Surveillance Utilization Review Services
- Kathy Crawford, R.N., Nurse Consultant, Bureau of Insurance

The state exam team conducts the HMO examination using a two-part process. First, the state exam team participates and observes the on-site NCQA accreditation review. Once the IATF receives a copy of the HMO's NCQA accreditation report, the IATF uses the NCQA's findings to credit the HMO for compliance with state standards, provided the state standard is equivalent to the NCQA standard. Second, the state exam team returns to the HMO to complete an independent examination by assessing elements of the HMO's compliance with state-specific standards not covered by NCQA.

In December 2000, Aetna US HealthCare's three-day re-accreditation survey by a NCQA team in Portland was monitored by the state examination team. It is significant to note that both the NCQA national office and the NCQA survey team were very complimentary of Maine's process and personnel. Upon receiving the NCQA final report the state exam team analyzed the information from NCQA to determine if specific portions of the state examination could be deemed acceptable, to avoid re-examination of specific areas by the state exam team. In July, the state exam team examined Aetna US HealthCare, targeting specific areas in Maine statutes and regulations not covered by the NCQA review. A draft report was prepared in August and submitted to Aetna US HealthCare for their review and comment. The IATF received a twenty-seven (27) page response from Aetna US HealthCare. The IATF addressed Aetna US HealthCare's points in a separate letter before a final report was prepared in October. The final report of the periodic quality examination for Aetna US HealthCare Maine can be found on the Bureau of Insurance Website at http://www.state.me.us/pfr/ins/Aetna.htm.

E. Advisory Committee

The Consumer Health Care Advisory Committee met five times during calendar year 2001. The committee reviews the work of the Consumer Health Care Division and made recommendations for

improving outreach and the operations of the division. The Division notes the passing of Dr. John Marvin, a dedicated advocate for consumers. The membership of the Consumer Health Care Advisory Committee is as follows:

- Jane Saxl, Chair
- Senator Lloyd Lafountain
- Representative Christopher P. O'Neil
- Susan Dore
- Joe Ditre
- Dr. Lani Graham
- Robert Goldman
- Robert Philbrook
- Christine Zukas-Lessard (ex-officio)
- S. Catherine Longley (ex-officio)

III. Major Legislative Changes

Most legislative changes did not become effective until September 21, 2001, so it was difficult to determine the full impact on the health insurance market by the time this report was prepared. However, some of these legislative changes required the Bureau of Insurance to implement changes in current health insurance regulations.

Legislative Document 204 (P.L. 2001, c. 369) eliminated the requirement that a voluntary private purchasing alliance offer at least three different carriers through the alliance. Additionally, the law allows the Superintendent of Insurance to waive the requirement that benefit plans offered through a preferred provider arrangement have a differential of no more than 20% between the benefit levels paid to participating and nonparticipating providers. As a result of this legislative change, the CHCD will amend Rule 360 "Requirements Applicable to Preferred Provider Arrangements."

Several legislative changes required that insurance companies file amended certificates of coverage, or forms for approval by the Superintendent. Two insurance analysts review the materials submitted by the insurance carriers to determine if the forms and certificates comply with the statutory changes. 1,761 forms and certificates were reviewed and approved or disapproved this year. Thirty-four (34) forms are currently pending additional information from a carrier and eighteen (18) forms are waiting review by the analysts. Listed below is some of the legislation that affected forms and certificates that the CHCD reviews:

- Legislative Document 217 (P.L. 2001, c. 16) clarified that an insurer, nonprofit hospital and medical service organization, or HMO may not deny, cancel, refuse to renew or restrict coverage of any person or request additional charges based on the fact or perception that the applicant or insured is, or may become a victim of domestic abuse. If the insurer or HMO issues an adverse insurance decision based on a medical condition known to be related to domestic abuse, then the insurer must justify its decision to the applicant or insured in writing.

- Legislative Document 251 (P.L. 2001, c. 299) repealed the definition of "medical necessity" and "medically appropriate health care" in the Health Plan Improvement Act and replaces these terms with a definition of "medically necessary health care."

- Legislative Document 323 (P.L. 2001, c. 408) required health plans that provide coverage for urgent eye care services to allow enrollees to self-refer for a maximum of 2 visits for each occurrence requiring eye care services from an eye care provider who participates in the carriers health plans.

- Legislative Document 1217 (P.L. 2001, c. 400) established objective criteria to determine whether a small business qualifies as a two-person group in order to purchase small group insurance coverage. The law clarifies how small employers may demonstrate that the employer qualifies for a small group policy by providing documentation, such as employment tax forms, and payroll statements.

- Legislative Document 1703 (P.L. 2001, c. 347) requires health insurance carriers to offer optional benefits for domestic partners of health plan members in individual and group policies at appropriate rates and under the same terms and conditions as coverage for spouses of health plan members. The offer of this optional coverage is made to the policyholder, and coverage is subject to a person meeting the definition of domestic partner under the act.

- Legislative Document 1742 (P.L. 2001, c. 258) clarifies the requirement for coverage of newborns under maternity benefits by specifying the newborns are not subject to a separate deductible. It also requires health insurers to provide a certificate of creditable coverage to insureds that are terminating coverage to facilitate an individual's transition to new coverage by providing evidence that the individual had prior coverage.

IV. Analysis[1]

The CHCD staff continually reviews consumer complaints as well as telephone inquiries to identify trends. Staff continues to work with carriers in resolving and works to provide information and educational materials to consumers.

The CHCD uses the knowledge gained in its work to identify complaint patterns and carrier-specific complaint trends. Staff assists consumers whenever possible to resolve their complaints. When the Division identifies complaint trends, they were brought to the attention of the carriers through both formal and informal communication.

Each carrier has its own unique referral and authorization system and requires members and/or providers to obtain the carrier's approval before certain services are reimbursed. Although these systems are not designed to be onerous or to restrict access to care, the CHCD works with carriers, providers, and consumers to find ways to simplify the processes and improve awareness.

Persons with long-term, chronic conditions and individuals with long-term, complicated mental health and behavioral health needs often complain when the covered benefits are not as extensive as they believe they require. The CHCD staff monitors compliance with those statutory provisions that require the carrier to establish procedures to allow an enrollee with a special condition requiring ongoing care from a specialist to receive a standing referral to a specialist participating in the carrier's network for treatment of that special condition.

[1] PL 1997, c. 792 §G (2) charges the Consumer Health Care Division with "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..."

The rural nature of Maine can present chalanges that may be evident in more urban settings. Commercial carriers have difficulty contracting with mental health providers because of the limited number of psychiatrists, pediatric and adolescent psychiatrists, and acute care mental health facilities in Maine. Some of the current acute care facilities are unable to meet the need of the more challenging persons with behavioral problems. The CHCD staff continually monitors compliance with accessibility standards as well as continuity of care for the enrollee in the event that a carrier terminates a provider or the provider elects to no longer participate with the carrier.