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Bureau of Insurance Consumer Health Care Division
Annual Report to the Legislature for the Year 2002

January 10, 2003

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Governor

Anne L. Head
Acting Commissioner

Alessandro A. Iuppa
Superintendent

MAINE DEPARTMENT OF
Professional
& Financial
Regulation

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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). The CHCD, now in its fourth year of operation, focuses it efforts on consumer assistance, outreach, and oversight of insurer compliance with statutory and regulatory issues important to Maine consumers.

The Division is responsible for the following activities:

- Review and approval of health insurance forms,
- Investigation and resolution of consumer health insurance complaints,
- Approval of the licenses of Medical Utilization Review Entities,
- Review and approval of long-term care insurance forms,
- Oversight of the Bureau's external review process,
- Drafting and review of health insurance rules,
- Bringing enforcement actions against carriers when violations occur,
- Review of managed care plans for compliance with provider network adequacy measures,
- Approval of the licenses for Preferred Provider Arrangements,
- Developing outreach and educational materials,
- Drafting reports on issues involving health policy,
- Participating as a survey team member of the Interagency Task Force for the Quality Oversight of Commercial Health Maintenance Organizations (HMOs),
- Tracking, trending, and analyzing data,
- Answering consumer telephone inquiries through the toll-free Consumer Assistance Hotline,
- Entering consumer complaint data into the complaint database for trending purposes,
- Review of complex complaints that include determinations of medically necessary care and complex health questions,
- Conducting outreach to a variety of groups,
- Providing information to consumers regarding health care plan options and obtaining health care coverage and services, and
- Assisting health plan enrollees in understanding their rights and responsibilities.

I. Accomplishments

A. Consumer Assistance

- **Inquiries**

CHCD staff responded to 7,222 telephone inquiries during 2002, compared to 6,824 in 2001. The most frequent inquiries related to:

- Medicare Supplement insurance
- Individual insurance
- Claim denials
- The high cost of health insurance (these calls became more frequent as the year progressed).

The CHCD staff also responded to requests for consumer assistance from state and federal legislative officials who had been contacted by constituents. Like the phone inquiries, these requests for assistance on behalf of constituents encompass a wide range of health insurance related issues.

"This is very good information. Thank you very much for your response to my inquiry." ...Consumer

Staff members are able to immediately assist consumers with inquiries by providing verbal information, referring callers to the Bureau's web site (www.MaineInsuranceReg.org), and/or mailing issue-related brochures. For issues not within the Bureau's jurisdiction, CHCD staff refers consumers to the appropriate agencies, such as the Maine Department of Human Services (regarding MaineCare or elder issues, for example) and the U.S. Department of Labor (regarding such federal laws as ERISA, COBRA or HIPAA).

"Thank you, I appreciate the info and sources. " …Consumer

- **Complaints**

During 2002, the CHCD responded to 724 written health insurance complaints filed by health plan enrollees, policyholders, insurance producers, and health care providers. This compares to 710 written complaints in the prior year. The complaints concerned health insurance carriers, utilization review entities, and third party administrators. Enrollee and policyholder complaints most often concern a 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 timeframes for the exchange of information between the carriers and Bureau staff can 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.

"Thank you for the information and for taking the time to help me. The information sent was very useful. Thanks again." …Consumer

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 surgical procedure or an inpatient stay has been denied by a carrier or health plan. Bureau staff members have been able to resolve some of those situations immediately, if it is evident the carrier's denial is flawed or based on specific requirements contained either in the consumer's insurance contract or in Maine law. CHCD staff was instrumental in assisting with the recovery of $910,490 for enrollees and policyholders in 2002, compared to $890,507 in 2001. Most often, the recovered funds are from previously denied claims.

"Mr. Roberts, I want to thank you for the outstanding work that you did on my insurance problem. It was a truly a professional job! You did in several weeks, what (carrier) couldn't correct in year and half. Thanks again."
…Consumer

Frequently the staff is able to assist consumers in achieving their desired results, however, there are instances where the Bureau is unable to assist the enrollee or policyholders to their satisfaction. There are also instances when Bureau staff also must explain the basis and/or rationale for the carrier's decision to enrollees. Generally, these cases include situations where the carrier is appropriately administering contract exclusions or the plan is exempt from state regulation due to federal law. 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. They also refer those consumers to the U.S. Department of Labor or other agencies, as appropriate.

The CHCD staff were key participants in the development of a new Bureau of Insurance complaint database. The resulting complaint database is used for all areas of insurance and produces meaningful management reports and statistics.

"Thank you so much, Patty. You and your agency have done so much for me. I am so appreciative. A nice holiday to you also."
…Consumer

The CHCD staff works proactively with the insurance carriers to identify trends in consumer complaints in order to remedy the problems before they result in violations of the insurance code. However, the Superintendent entered into four consent agreements and issued one letter of reprimand in 2002, all stemming from consumer complaints received and investigated by CHCD. The consent agreements were issued for: failure to meet the obligations of an HMO to coordinate the referral process and to provide consumers with notification of the referral and all relevant information; denial of a Medicare Supplement application when that applicant was entitled to guaranteed issue of a Medicare Supplement policy; failure to provide a timely substantive response to the Bureau in connection with a consumer complaint; and failure to pay for routine newborn care. The letter of reprimand addressed violations of Rule 275, which provides that when a consumer who has a Medicare Supplement policy becomes eligible for Medicaid, the carrier must permit the consumer to suspend the policy and must offer to reinstate the Medicare Supplement policy when Medicaid eligibility ends. The consent agreements and the letter of reprimand are available on the Bureau of Insurance webpage (www.MaineInsuranceReg.org).

"Mr. McGonigle, I appreciate your efforts to assist us in settling the outstanding bill with (carrier). We did receive payment from (carrier) in response to the complaint I sent to your office. Please accept my sincere thanks for assisting us in resolving this claim."
…Consumer

"Dear Mike, Thank you for your successful efforts to get (carrier) to cover our daughter's treatment through the (program) last summer. We were amazed and pleased to receive the 90% reimbursement plus interest, due to your diligent pursuit of this matter.

Over the months that you worked on this, we were continuously impressed with your professional manner, thoroughness and tenacious attention to this case on our behalf. We are grateful to have such excellent support form the Bureau of Insurance in ensuring that the insurance company finally, did the right thing."… Consumer

In the CHCD's analysis of the consumer complaints and inquiries, two findings emerge:

- The single greatest issue that prompts Maine residents to contact the Consumer Health Care Division is finding affordable health insurance coverage;
- Many residents who contact the Division are confused about their benefits, and the rules that they must follow to receive the maximum benefits of their coverage.

- **Outreach and Education**

Division staff participated in several public speaking events this year, including;

- American Association of Healthcare Administrative Management;
- Maine Alliance of Health Underwriters;
- Billing Subcommittee of the Maine Hospital Association;
- Healthcare Financial Management Association;
- Insurance Women of Downeast Maine;
- Bath Senior Citizens Center workshop;
- Emergency Mental Health Care Providers;
- Hall-Dale High School;
- Rural Health Conference on Affordability and Accessibility of Health Insurance; and
- Health Insurance Partnership (National Panel).

"Thank you Mr. Griswold...it was very kind of you to respond to my note. All the best."…Consumer

One of the objectives of the CHCD is to educate consumers about how to advocate for themselves so that they are more comfortable with the system and are aware of their rights. The CHCD also continues to encourage communication between carriers and providers during presentations to these groups.

Division staff provide information to consumers by developing written educational materials, both for the website and hard-copy distribution. These materials, found in the Appendix to this report, include:

- "A Consumer's Guide to Health Insurers Doing Business in Maine" (http://www.state.me.us/pfr/ins/healthcare_report_card_2001.htm), with much more detail than past versions;
- "How Your Health Insurance Dollar Is Spent," a brochure explaining of the cost drivers of insurance premiums (http://www.state.me.us/pfr/ins/Health_Insurance_Dollar.htm);
- "Guide to Requesting an Independent External Review When Your Health Insurance Company or HMO Denies Benefits for Health Care Services," an updated explanation of the external review process (http://www.state.me.us/pfr/ins/external_review.htm);
- "Maine Tax Qualified Long Term Care Insurance Policies," an explanation of Maine tax qualified

long-term care insurance policies (Internet only) (http://www.state.me.us/pfr/ins/ltc_tax_qualified.htm) and a list of certified tax qualified policies (http://www.state.me.us/pfr/ins/ltctax2002.htm);

- "Maine Insurance Update." the Bureau's quarterly newsletter, which contains articles on Maine tax qualified long-term care insurance policies (http://www.state.me.us/pfr/ins/Fall2002newsletter.htm) and on the increase in fraudulent health insurance companies (http://www.state.me.us/pfr/ins/nletsummer2002.htm); and
- Frequently Asked Questions (http://www.state.me.us/pfr/ins/ins_faq.htm) and Glossary sections of the Bureau's website, which have been updated to comply with statutory changes and reflect the types of inquiries received through the Consumer Assistance Hotline.

"I just wanted to take this time to say thank you for all of your help in the matter of myself and the (carrier). I received word from (provider) that the matter has been resolved. Again, I thank you. Its comforting to know that help is out there." *Sincerely… Consumer*

Finally, the Division promotes coordination with other organizations that assist consumers, including the Maine Department of Human Services, the Maine Health Data Organization and the Maine Advisory Council on the Education of Children with Disabilities.

B. External Review

Maine consumers have 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 during 2002 has worked with two independent external review organizations, The Center for Health Dispute Resolution, and IPRO.

The Bureau received fifty three requests for external review that qualified under the statute. Thirty of the cases referred to external review upheld the carrier's initial determination. Nine cases resulted in the carrier's decision being reversed. In twelve cases, the carrier reversed its decision before the external review hearing. In two cases, the enrollees withdrew their requests for external review.

CHCD received seven 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 contractual issues rather than medical issues.

The Bureau estimates it will continue to receive between 40 and 50 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 under *Consumer Info*.

"Your assistance and understanding are greatly appreciated in helping to resolve this matter. ….It was heartening to know you were there for me." Respectfully,…Consumer

C. Licensing Activity

Currently, there are 72 Medical Utilization Review Entities (UREs) licensed in Maine including new entities that were initially licensed in 2002. 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. 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. In addition to the 19 preferred provider arrangements already registered, five new preferred provider arrangements were registered in 2002. Preferred provider arrangements are reviewed for compliance with accessibility, utilization review, grievance and appeal, contractual, provider compensation, consumer notification, and emergency access requirements under Maine law. A list of Maine licensed preferred provider arrangements can be found on the Bureau's web site under *Producer/Entity Information*.

The CHCD staff reviews HMO provider networks to determine if they comply with the accessibility standards set forth in statute and regulation. HMO applications to expand the geographic service area are also reviewed by CHCD staff to determine if an adequate network of providers is available to render medical services to enrollees. The staff is 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. Members of CHCD staff monitor the situation to assure that enrollees are provided adequate notice and opportunity to find alternative providers and to make sure that continuity of care for enrollees currently receiving medical services is addressed by the carrier.

> *"I am writing to inform you that we received payment from (carrier) regarding the claims that were outstanding from July 2001. Thank you for your help. It was greatly appreciated."… Consumer*

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…." The Inter-Agency Task Force (IATF) for HMO Quality was established by PFR and DHS to perform joint agency functions as required by the memorandum of understanding.

Each year, the Maine HMOs that are to be examined are notified by the IATF chair that, pursuant to 24-A M.R.S.A. § 4215, BOI and DHS will conduct a coordinated, on-site state exam on the quality of health care and customer services. In the interest of minimizing duplication of time and resources, the state examinations are coordinated with each HMO's triennial National Committee for Quality Assurance (NCQA) accreditation review cycle. (Although participation in NCQA's accreditation and certification programs is voluntary, more than half the nation's HMOs, including the HMOs currently operating in Maine, currently participate.)

The CHCD Director chairs the IATF. A four-member state exam team, under the direction of the IATF, conducts the on-site state exams. In 2002, the state exam team consisted of:

- Ellen Austin-Reichtal, R.N., Bureau of Medical Services, Department of Human Services (DHS)
- Margaret Ross, R.N., former Director of DHS's Surveillance Utilization Review Services
- Joanne Rawlings-Sekunda, M.P.P., Policy Development Specialist, Bureau of Insurance
- Ruth Martin, M.B.A., M.P.H., Independent consultant for NCQA

The state exam team conducts the HMO examination using a two-part process.

- First, the team observes the on-site NCQA accreditation review. Once the IATF receives a copy of the HMO's NCQA accreditation report (usually several months later), it uses the NCQA's findings to credit the HMO for compliance with any state standards that are equivalent to the NCQA standards.
- Second, the team returns to the HMO to assess the HMO's compliance with state-specific standards not covered by NCQA. It then develops a report of its findings.

In 2002, the IATF conducted quality review activities related to three of Maine's HMOs:

- ***CIGNA HealthCare of Maine, Inc.*** Cigna's, NCQA survey had been completed in 2001. Upon receiving the NCQA final report the state exam team analyzed the information to determine if specific portions of the NCQA examination could be deemed acceptable, in order to avoid re-examination of specific areas by the state exam team. In March, the state exam team examined CIGNA, targeting the specific areas in Maine statutes and regulations not covered by the NCQA review. A report was prepared in March and submitted to CIGNA for its review and comment. In July, the IATF Chair and a member of the state review team met with CIGNA to develop an action plan to deal with the deficiencies identified by the review and in August 2002, the quality report was completed.
- ***Anthem Health Plans of Maine, Inc. and Maine Partners Health Plan, Inc.*** In April, Anthem Health Plans of Maine, Inc. and Maine Partners Health Plan, Inc. participated in the three-day re-accreditation survey by a NCQA team, which was monitored by the state examination team. 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 November, the state exam team examined both plans, targeting the specific areas in Maine statutes and regulations not covered by the NCQA review. A draft report is currently being prepared.

Advisory Committee

The Consumer Health Care Advisory Committee met twice during calendar year 2002. The committee reviews the work of the Consumer Health Care Division and made recommendations for improving outreach and the operations of the division. The membership of the Consumer Health Care Advisory Committee is as follows:

- Jane Saxl, Chair
- Senator Lloyd Lafountain
- Representative Christopher P. O'Neil
- Jeff Baker, Sabre Yachts

- Joe Ditre, Director, Consumers for Affordable Health Care
- Dr. Lani Graham
- Robert Goldman, Maine Council of Senior Citizens
- Robert Philbrook, We Who Care
- Shirley Powell
- Christine Zukas-Lessard (ex-officio)
- Anne Head (ex-officio)

III. Legislative and Regulatory Activities

The 120th Legislature passed a number of laws which required the Consumer Health Care Division to revise the Bureau's current health insurance rules, submit reports to the Legislature, or make changes to filing procedures.

Bureau of Insurance Rule 750 (Standardized Health Plans) was amended in March, 2001. Certain changes made to the rule before final adoption and two of those changes – making inpatient hospital services subject to maximum out-of-pocket limits, and permitting copayments for inpatient hospital services on a "per admission" basis up to $500 per admission -- appeared to pose compliance problems for regulated entities. In addition, the absence of a transition clause for several of the new plan requirements did not provide HMOs with sufficient time to bring health plans into compliance. In August of 2001, the Bureau promulgated emergency amendments to Rule 750 to address these issues. Subsequent to adopting the amendments on an emergency basis, the Bureau initiated the major substantive rulemaking process to adopt the emergency amendments on a permanent basis. Final adoption of the major substantive rule occurred in June, 2002.

P.L. 1999, Chapter 222, "*An Act to Clarify Basic Health Care Services to be offered by Maine Health Maintenance Organizations;"* P.L. 1999, Chapter 742, "*An Act to Establish a Patient's Bill of Rights;"* and P.L. 2001, Chapter 288, "*An Act to Define 'Medically Necessary Health Care' and Clarify its Application by Health Plans and Managed Care Plans;"* all made revisions to the *Health Plan Improvement Act* (Title 24-A M.R.S.A., Chapter 56-A) and required amendments to Bureau Rule Chapter 850 (Health Plan Accountability). In particular, the rule has been amended to apply to "all health carriers, utilization review and managed care plans." CHCD staff completed the changes to the rule and it was finally adopted earlier this year.

P.L. 2001, Chapter 369, "*An Act to Encourage the Creation of an Alliance for the Purpose of Purchasing Health Insurance,"* made revisions to the *Preferred Provider Arrangement Act* (24-A M.R.S.A. Chapter 32) and required amendments to Bureau Rule Chapter 360 (Requirements Applicable to Preferred Provider Arrangements) to provide standards for waiver of the 20% limit on the benefit differential. These amendments, and revisions made in order to comply with amendments to the *Health Plan Improvement Act* (24-A M.R.S.A. Chapter 56-A) made by the 119th Legislature, Second Regular Session, were completed by CHCD staff and were effective on September 15, 2002.

P.L. 2001, Chapter 679, "*An Act to Reinstate Tax Deductibility of Qualified Long-term Care Insurance,"* establishes an income tax deduction for persons purchasing certified long-term care policies and requires the Bureau to certify long-term care policies, upon request, if the policy complies with the requirements for long-term care policies established under Title 24-A. CHCD staff developed a procedure for certifying non-qualified long-term care policies and notified long-term care carriers of the new law.

Resolve 2001, Chapter 56, *"A Study of the Implications of Including Pharmacists as 'Health Care Practitioners' under the Maine Health Security Act and the Feasibility, Cost and Implications of Establishing a Standardized Pharmaceutical Benefits Identification Card,"* directed the Bureau to develop and submit these studies to the Legislature. The Bureau reported the results of the studies to the Joint Standing Committee on Health and Human Services on January 1, 2002. The Committee held a briefing on the standardized pharmaceutical benefits identification card study in March. In April, the Joint Standing Committees on Health and Human Services and on Banking and Insurance asked the Bureau to convene the interested parties to reach consensus on identification card standards. The Bureau convened three meetings with health carriers, pharmacists, and other interested parties. As a result of these meetings, the interested parties agreed to group the information needed to process pharmacy claims together on the member identification card. This agreement was memorialized, without the need for statute or regulation, in a Memorandum of Understanding signed by all parties that participated in these meetings. The Bureau has prepared a report on the outcome of these meetings and the report will be submitted to the First Regular Session of the 121st Legislature.

Additionally, two laws that were enacted during the First Regular Session of the 120th Legislature and became effective January 1, 2002, also impact the work of the CHCD:

- P.L. 2001, Chapter 408, *"An Act Concerning Patient Access to Eye Care Providers."* This law requires health plans that provide coverage for eye care services through participating eye care professionals to allow enrollees to self-refer for a maximum of two visits for each occurrence requiring eye care services from an eye care provider who participates in the insurer's health plans. Eye care services are defined as those urgent health care services related to the examination, diagnosis, treatment, and management of conditions, illnesses and diseases of the eye that if not treated within 24 hours present a serious risk of harm.

- P.L. 2001, Chapter 423, *"An Act to Provide Health Insurance Coverage for General Anesthesia and Associated Facility Charges for Dental Procedures for Certain Vulnerable Persons."* This law requires individual and group policies issued or renewed on or after January 1, 2002, to include coverage for general anesthesia and associated facility charges for dental procedures given in a hospital for certain eligible enrollees, including persons with developmental disabilities and persons whose health is compromised and for whom general anesthesia is medically necessary. The legislation does not require coverage of the professional fee of the dentist or other charges for the dental procedure itself. The law further provides that for the required benefits, coverage under a dental insurance policy is primary and health insurance coverage is secondary.

Finally, two bills passed in 2002 during the Second Regular Session of the 120th Legislature have generated a particularly high level of interest among small business owners concerned with the cost health insurance. CHCD has received a significant number of inquiries related to these laws:

- P.L. 2001, Chapter 677, *"An Act to Address the Health Coverage Crisis for Maine's Small Businesses and Self-employed Persons."* This legislation created the Maine Small Business Health Coverage Plan. This Plan is intended to provide comprehensive health care coverage at affordable prices to small employers, including self-employed individuals, their employees and dependents. Its governing Board will develop a business plan, issue a request for proposals from qualified bidders to provide health care coverage to Plan enrollees, and award a bid. The Board will coordinate with MaineCare to maximize the use of federal Medicaid funds; MaineCare must

bid on the request for proposals and administer the Plan if selected. Coverage is to be available by 2004.

- P.L. 2001, Chapter 708, *"An Act to Establish the Maine Consumer Choice Health Plan."* The Maine Consumer Choice Health Plan is established as an independent executive agency to negotiate and contract with carriers to provide a board-authorized choice of health benefits coverage to eligible enrollees, including small employers, government employers, individuals, and, possibly, large employers. By 2006, its Board shall initiate a request for proposal process seeking bids from qualified nonprofit organizations for the administrative and financial responsibility of the Plan, which will include fee-for-service, HMO, and point-of-service options.

IV. Analysis[1]

The CHCD uses the knowledge gained in its work, including reviews of consumer complaints and inquiries, to identify complaint patterns and carrier-specific complaint trends. When the Division identifies complaint trends, they are brought to the attention of the carriers through both formal and informal communications. Staff works to provide information and educational materials to consumers and works with carriers in resolving problems.

Each carrier has its own unique referral and authorization systems, 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, the CHCD works with carriers, providers, and consumers to find ways to simplify the processes and improve awareness.

The rural nature of Maine can present special challenges. 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 and works with carriers to ensure that consumers can access the care they need.

Finally, as is the case across the country, health insurance costs in Maine continue to climb. These costs are driven by a number of interrelated factors, which makes dealing with the problem extremely complicated. Hospital care accounts for about 40% of these costs; services provided by doctors or other health care professionals account for another 30%. Prescription drugs only account for about 12%, but are rising rapidly. Other costs include: more expensive medical technologies, administrative services by insurance companies, and privately insured people subsidizing underpayments by Medicare and Medicaid.

If you are interested in additional details in this report or have questions you are encouraged to contact the Consumer Health Care Division in the Maine Bureau of Insurance by calling toll free 800-300-5000.

"Please find enclosed a bill from (provider) that per our conversation has been paid. Again, thank you for all your help. I feel much better today! Thank You!" Consumer

[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…"

Appendices

A Consumer's Guide to Health Insurers Doing Business in Maine

How Your Health Insurance Dollar Is Spent

Guide to Requesting an Independent External Review When Your Health Insurance Carrier Denies Benefits for Health Care Services

Maine Tax Qualified Long Term Care Insurance Policies: Starting with Tax Year 2002: New Tax Certification Program For Deducting Long Term Care Insurance Premiums on Maine Income Tax Returns

Long Term Care Policies Certified for Income Tax Incentives in Tax Years Beginning Jan. 1, 2002; Applicable to Forms Approved by Bureau of Insurance after January 1, 2000 (24-A MRSA § 5075-A)

New Tax Certification Program For Deducting Long Term Care Insurance Premiums on Maine Income Tax Returns

Beware of Unlicensed Health and Medicare Supplement Insurers (Newsletter article)

Frequently Asked Questions: Health

MAINE DEPARTMENT OF
Professional & Financial Regulation

A Consumer's Guide to...

Health Insurers Doing Business in Maine

(Information for the Year 2001)

Angus S. King, Jr.
Governor

Alessandro A. Iuppa
Superintendent

Table of Contents

Some Information About This Brochure...

Maine's Health Plan Improvement Act requires that all licensed insurers that sell health insurance in Maine report specific information about their operation in Maine to the Bureau of Insurance. The information in this brochure covers the period from January 2001 through December 2001.

You can find the following Maine specific information:

* The number of consumer complaints received against insurers (pages 4 & 5).
* The number of utilization review decisions the companies made that were not in favor of the covered person (page 6).
* General information on the insurers including the number of people covered under their plans, customer service numbers and hours, the products that they sell in Maine, a web site address, and whether the company has received accreditation from one of the organizations who rates managed care companies based on specific standards of operation.

With the exception of the complaint information on page 7, the information in this brochure was reported to the Bureau of Insurance by the companies. Consequently, this information should be just one tool that you use when you evaluate health insurers.

What is Accreditation?

A company receives accreditation when they meet specific standards established by the rating organization. Organizations that review health insurers and HMOs for accreditation look at some or all of the following areas: access to care; quality of care; utilization review; customer rights; preventive health services; and the efficiacy, efficiency, appropriateness, availability, timeliness, and continuity of health care. Several organizations perform reviews and have specific accreditation standards. Two of the major accreditation organizations are the National Committee on Quality Assurance (NCQA) and the American Accreditation Healthcare Commission (URAC).

What is NCQA?

NCQA's accreditation program includes selected performance measures in such key areas as member satisfaction, quality of care, and access to needed care with good customer service. To learn more about NCQA accreditation and to get more detailed information about how a plan is rated, visit NCQA's Health Plan Report Card on their web site at ***www.ncqa.org***.

What is URAC?

The American Accreditation Healthcare Commission's (URAC) accreditation program is intended to promote quality and accountability for health care organizations. To receive URAQ accreditation, managed care organizations must demonstrate quality in both their organizational structure and operations by delivering high quality services to their members in claims review processing, complaints and grievances, and case management. For more information you can visit URAC's web site at ***www.urac.org***

COMPLAINTS RECEIVED BY THE COMPANIES

A **complaint** is a written complaint against an insurer. The complaint may be filed by the person who is covered under the health insurance plan or by someone else on behalf of the insured person.

Please note: The chart below shows complaints received by the insurer where the covered person (or someone on behalf of the covered person) was not happy with a decision of the insurer/HMO. The ***Reversal Rate**** is the percentage of insurer/HMO decisions that were made against the covered person and then were reversed after another review. For example, a 50% reversal rate shows that in 5 out of 10 complaints received, the insurer/HMO changed its initial adverse decision in favor of the covered person.

Complaints Reported to the Company (January 2001 - December 2001)

Insurer/HMO	Total Number of Covered Persons	Number of Complaints Received from Covered Persons	Number of Complaints that were Decided in Favor of the Covered Person after a Review and the Reversal Rate* (see above explanation)
Aetna Health, Inc.	82,884	530	169 32%
Anthem Blue Cross & Blue Shield of Maine	215,671 (under age 65) 57,305 (Medicare Supp)	1,197	456 38%
CIGNA HealthCare of Maine, Inc.	113,182	1,386	576 42%
Guardian Life Insurance Company of America	876	6	1 17%
Harvard Pilgrim Health Care	1,673	131	23 18%
John Alden Life Insurance Company	1,059	20	11 55%
Maine Partners Health Plan	47,832	222	92 41%
MEGA Life & Health Insurance Company	8,192	1	0 0
New England Life Insurance Company	8,699	0	0 0
Patriot Mutual (Dental Coverage Only)	31,585	30	15 50%
United Healthcare Insurance Company	53,258	45	28 62%

COMPLAINT RANKING The chart below shows the companies' complaint standing based on health insurance complaints that were received by the Bureau of Insurance in 2001 and that the Bureau determined were valid complaints. Valid complaints are those complaints where the Bureau found in favor of the covered person

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

The Bureau of Insurance publishes a separate brochure with the number of complaints that it received along with a comparison rating for each company (see the following page for a company's complaint rating) The entire complaint brochure is available on-line at: www.MaineInsuranceReg.org under "*Consumer Information.*"

NOTE: Many companies are part of an insurance "group." If you can't find your company on the chart, look at the lists below to see if it is part of a group.

Individual and Group Health Company and Group Name (see note above)	2001 Valid Complaints	2001 Written Premium in Maine	2001 Complaint Index
Aetna Health, Inc. (Aetna Group)	59	$210,239,696	2.7
Anthem Blue Cross & Blue Shield of Maine (Anthem Group)	12	$781,959,280	0.1
CIGNA HealthCare of Maine, Inc. (CIGNA Health Group)	38	$162,602,822	2.3
Guardian Life Insurance Company of America (Guardian Grp)	0	$7,154,362	0
Harvard Community Health Plan Group	12	$6,783,045	17.2
John Alden Life Insurance Company (Fortis Group)	0	$3,955,984	0
Maine Partners Health Plan (Anthem Group)	Included in Anthem Blue Cross & Blue Shield above		
MEGA Life & Health Insurance Company (United Grp of CO)	3	$13,748,598	2.1
New England Life Insurance Company (Metropolitan Group)	0	$498,031	0
Patriot Mutual (Patriot Group) (Dental Coverage Only))	0	$7,425,876	0
United Healthcare Insurance Company (United Healthcare Grp)	6	$35,194,099	1.7

AETNA GROUP

AETNA LIFE INS CO
AETNA HEALTH INC

ANTHEM INSURANCE COMPANY GROUP

ANTHEM HEALTH PLANS OF MAINE INC
MAINE PARTNERS HEALTH PLAN

CIGNA HEALTH GROUP

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

FORTIS GROUP

AMERICAN BANKERS INS CO OF FL
AMERICAN BANKERS LIFE ASSUR CO OF FL
AMERICAN MEMORIAL LIFE INS CO
AMERICAN RELIABLE INS CO
AMERICAN SECURITY INS CO
FORTIS BENEFITS INS CO
FORTIS INSURANCE CO
JOHN ALDEN LIFE INS CO
UNITED FAMILY LIFE INS CO

GUARDIAN LIFE GROUP

BERKSHIRE LIFE INS CO OF AMERICA
GUARDIAN INS & ANNUITY CO INC
GUARDIAN LIFE INS CO OF AMERICA
PARK AVENUE LIFE INS CO

HARVARD COMMUNITY HEALTH PLAN GROUP

HARVARD PILGRIM HEALTH CARE INC

METROPOLITAN GROUP

GENERAL AMERICAN LIFE INS CO
METLIFE INVESTORS USA INS CO
METLIFE SECURITY INS CO LA
METROPOLITAN CASUALTY INS CO
METROPOLITAN GENERAL INS CO
METROPOLITAN INS & ANNUITY CO
METROPOLITAN LIFE INS CO
METROPOLITAN PROPERTY & CASUALTY INS CO
METROPOLITAN TOWER LIFE INS CO
NEW ENGLAND LIFE INS CO
PARAGON LIFE INS CO
TEXAS LIFE INS CO

PATRIOT GROUP

PATRIOT LIFE INS COMPANY
PATRIOT MUTUAL INSURANCE COMPANY

UNITED GROUP OF CO

CHESAPEAKE LIFE INS CO
MEGA LIFE & HEALTH INS CO

UNITED HEALTHCARE INSURANCE GROUP

UNITED HEALTHCARE INSURANCE COMPANY

UTILIZATION REVIEW

Utilization Review (UR) is a program used in managed care plans that is designed to reduce unnecessary medical inpatient or outpatient services. An individual or organization, on behalf of an insurer, reviews the necessity, use, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

An **appeal on an unfavorable UR decision** occurs when a consumer asks an insurer to reconsider its refusal to pay for a medical service that the insurer considers not medically necessary. Insurers are required to have medical professionals review the appeals that they receive. Some common UR issues involve whether a hospital admission is necessary based on the medical condition, how long a stay in the hospital should be, and medical procedures.

A **reversed UR appeal** takes place when the health insurer decides in favor of the consumer and reverses its initial decision that it would not cover a service or procedure. ***Reversal Rate**** is the percentage of insurer/HMO decisions that were made against consumers and then were reversed after an additional review. For example, a 50% reversal rate shows that in 5 out of 10 complaints, the insurer/HMO changed its initial decision to favor the covered person.

Utilization Review Determinations and Appeals (January 2001 - December 2001)

Insurer/HMO	Total Number of UR Requests made to the Insurer/HMO	Number of Decisions Insurer/HMO made to Deny Services for the Covered Person	Number of Decisions made to Deny Services that were Appealed by the Covered Person	Number of Denials that were Reversed by the Insurer/HMO when the Covered Person Appealed with Reversal Rate* (see above explanation)
Aetna Health, Inc.	10,726	300	56	26 46%
Anthem Blue Cross & Blue Shield of Maine	12,394	490	433	159 37%
CIGNA HealthCare of Maine, Inc.	23,136	3,108	452	163* 36%
Guardian Life Insurance Company of America	432	10	3	0 None reversed
Harvard Pilgrim Health Care, Inc.	3,746	82	78	26 33%
John Alden Life Insurance Company	169	2	2	0 None reversed
Maine Partners Health Plan	10,424	203	36	14 39%
MEGA Life & Health Insurance Co**	N/A	N/A	N/A	N/A N/A
New England Life Insurance Company	0	0	0	0 No UR requests
Patriot Mutual Insurance Company (Dental Coverage Only)	359	Unknown	30	13 43%
United Healthcare Insurance Company	503	0	0	0 0

*Includes 15 partial reversals.
**Company does not sell health plans in Maine that include Utilization Review.

INDEPENDENT EXTERNAL REVIEW (January 2001 - December 2001)

Maine law gives consumers the right to request an independent external review when a health insurance carrier (insurance company or HMO) denies benefits for health care services. Consumers are entitled to an external review when benefits are denied based on issues involving medical diagnosis, care or treatment, medical necessity, preexisting conditions, or denial of services because the insurance carrier considers the treatment to be experimental or investigational.

Before consumers request an external review, they must exhaust the health insurance carrier's first and second level appeal and grievance process as described in their policy. For information regarding how to request an independent external review, the Bureau provides an on-line brochure called "Guide to Requesting an Independent External Review...." which can be accessed at: www.state.me.us/pfr/ins/external_review.htm.

In the chart below, please note the following:

The **total number of external review decisions** column shows the number of requests for external reviews received in 2001 that qualified for external review and for which a written decision was issued.

The **reversed decisions** column shows the number of cases that were reviewed by external review organizations where the organization decided in favor of the consumer.

The **upheld decisions** column shows the number of cases that were reviewed by external review organizations where the organization agreed with the insurer's decision to deny coverage for the service or procedure.

The final column, **decisions reversed by the carrier before the external review was completed**, reflects cases sent to the external review organization in which the carrier re-evaluated the medical issues and agreed to pay the claim before a written decision was issued. This column does not include cases resolved before they were sent to the external review organization, or those cases where the carrier reached a satisfactory agreement with the insured because of administrative issues, coverage issues or considerations other than the re-evaluation of the medical appropriateness of the requested treatment.

The companies listed in this chart are the only companies (of those included in this brochure) that had independent external reviews in 2001.

Insurer/HMO	Total Number of External Review Decisions	Reversed Decisions	Upheld Decisions	Denials Reversed by the Carrier before the External Review was Completed
Aetna Health, Inc.	1	0	1	0
Anthem Blue Cross & Blue Shield of Maine	10	2	8	3
CIGNA HealthCare of Maine, Inc.	9	0	9	0

General Company Information

The following will give you general company information such as the number of people the company insures in Maine, the types of health products that are available from each company, addresses and web sites for contact information, and the availability of customer service phone lines.

Aetna Health, Inc. 1 Monument Square, Portland, ME 04101	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2001	72,387
Number of covered persons, in **self insured** health insurance plans as of December 31, 2001	10,497
Customer service phone numbers	1-800-323-9930 or 1-800-628-3323 (TDD)
Hours the customer service phone is staffed	8:00 am - 6:00 pm Monday – Friday
Web site	www.aetna.com
Products offered in Maine	HMO and Point of Service Small Group, Large Group, and Individual
Accreditation designation	NCQA accreditation

Anthem Blue Cross & Blue Shield of Maine 2 Gannett Drive, South Portland, ME 04106	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2001	215,671 (under age 65) 57,305 (Medicare Supplement)
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	0
Customer service phone numbers	Managed care: 207-822-8282 1-800-527-7706 Indemnity: 207-822-7272 1-800-482-0966 Medicare Supp 207-775-1550 1-800-422-4304
Hours the customer service phone number is staffed	8:00 am - 5:00 pm Monday - Friday
Web site	www.anthem.com
Products offered in Maine	Individual, Small Group, and Large Group HMO, Point of Service, Medicare Supplement, and non-managed care plans.
Accreditation designation	NCQA Excellent (highest accreditation rating - meets additional HEIDIS* performance standards) and URAC

General Company Information

CIGNA HealthCare of Maine, Inc. PO Box 447, Freeport, ME 04032	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2001	65,104
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	48,078
Customer service phone number (varies by type of product and possibly employer)	HMO: 1-800-249-3900 POS: 1-800-257-2277 BIW: 1-888-551-4072
Hours the customer service phone number is staffed	8:30 am - 5:00 pm Monday - Friday
Web site	www.cigna.com
Products offered in Maine	Individual, Small Group, Large Employer (HMO and Point of Service plans)
Accreditation designation	NCQA Excellent (highest accreditation rating - meets additional HEIDIS* performance standards)

Guardian Life Insurance Company of America 7 Hanover Square, New York, NY 10004	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2001	876
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	0
Customer service phone number	1-800-873-4542
Hours the customer service phone number is staffed	7:00 am - 8:00 pm (CST) Monday - Friday
Web site	www.glic.com
Products offered in Maine	Guardian Indemnity Plans - Small and Large Group
Accreditation designation	NCQA for UR management and URAC

*HEIDIS - is an NCQA tool used by health plans to collect data about the quality of care and service they provide. HEDIS consists of a set of performance measures that tell how well health plans perform in key areas: access to care & member satisfaction with the health plan and doctors.

General Company Information

Harvard Pilgrim Health Care, Inc. 93 Worcester Street, Wellesley, MA 02481	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2001	1,673
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	4,519
Customer service phone number	1-888-333-4742
Hours the customer service phone number is staffed	8:00 am - 7:30 pm Monday & Wednesday 8:00 am - 5:30 pm Tuesday, Thursday, & Friday
Web site	www.harvardpilgrim.org
Products offered in Maine	Small and Large Group HMO & Point of Service plans, HMO nongroup
Accreditation designation	NCQA Commendable (awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's requirements)

John Alden Life Insurance Company 501 W. Michigan Avenue, Milwaukee, WI 53203	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2001	1,059
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	0
Customer service phone number	1-800-800-1212
Hours the customer service phone number is staffed	7:30 am - 6:00 pm CST Monday - Friday
Web site	www.us.fortis.com
Products offered in Maine	Small Group PPO plans
Accreditation designation	URAC

General Company Information

Maine Partners Health Plan 2 Gannett Drive, So Portland, ME 04106	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2001	47,832
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	0
Customer service phone number	207-822-5172 or 1-800-622-0797
Hours the customer service phone number is staffed	8:00 am - 5:00 pm Monday - Friday
Web site	www.anthem.com
Products offered in Maine	Individual, Small Group, and Large Group (HMO and Point of Service plans)
Accreditation designation	NCQA Excellent (highest accreditation rating - meets additional HEIDIS* performance standards)

MEGA Life & Health Insurance Company 4001 McEwen Drive, Suite 200, Dallas TX 75244	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2001	8,192
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	0
Customer service phone number	1-800-527-5504
Hours the customer service phone number is staffed	7:00 am - 7:00 pm CST Monday - Friday
Web site	none
Products offered in Maine	Small Group Indemnity plans
Accreditation designation	N/A (no utilization review)

*HEIDIS - is an NCQA tool used by health plans to collect data about the quality of care and service they provide. HEDIS consists of a set of performance measures that tell how well health plans perform in key areas: access to care & member satisfaction with the health plan and doctors.

New England Life Insurance Company 8505 E. Orchard Road, Greenwood Village, CO 80111	
Number of covered persons in all **fully insured** health insurance plans issued in Maine as of December 31, 2001	0
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	8,699
Customer service phone number	1-800-633-8081
Hours the customer service phone number is staffed	8:00 am - 5:00 pm Monday - Friday
Web site	www.onehealthplan.com
Products offered in Maine	PPO, Indemnity, Point of Service, HMO
Accreditation designation	URAC

Patriot Mutual Insurance Company 14 Main Street, Brunswick, ME 04011	
Number of covered persons in all **fully insured** health insurance plans issued in Maine as of December 31, 2001	27,562
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	4,023
Customer service phone number	1-800-491-7336
Hours the customer service phone number is staffed	8:00 am—5:00 pm Monday - Friday
Web site	www.patriotmutual.com
Products offered in Maine	Traditional and PPO Dental plans to Small and Large Groups
Accreditation designation	N/A - Dental coverage only

United Healthcare Insurance Company 450 Columbus Blvd. Hartford, CT 06115	
Number of covered persons in all **fully insured** health insurance plans issued in Maine as	27,388
Number of covered persons in **self-insured** health insurance plans as of December 31, 2001	25,870
Customer service phone number	Varies by plan - shown on membership card
Hours the customer service phone number is staffed	8:00 am - 5:00 pm Monday - Friday
Web site	www.myuhc.com
Products offered in Maine	Small and Large Group (PPO and Ppoint of Sservice plans)
Accreditation designation	URAC

Our Mission

The Bureau of Insurance, within the Department of Professional and Financial Regulation, regulates the insurance industry for solvency and consumer protection. It does so through its examining and licensing procedures of insurance companies, by licensing producers, by reviewing rates and coverage forms, conducting audits, and by sponsoring programs that enhance awareness of and compliance with State laws. The Bureau has statutory authority to enforce the State's laws and rules pertaining to insurance, and it initiates investigations and holds hearings concerning possible infractions of them.

Alessandro A. Iuppa
Superintendent

Consumer information, including how to file a complaint and how to request an independent external review when you are denied benefits for health care services by your insurer can be found on the Bureau's web-site at: **www.*MaineInsuranceReg.org*** under "Consumer Information." Other consumer publications and information are available on-line at our web site.

Other ways to contact the Bureau of Insurance:

By phone
(800) 300-5000 (Maine only)
(207) 624-8475
TDD (207) 624-8563

By fax
(207) 624-8599

By mail
Bureau of Insurance
34 State House Station
Augusta ME 04333-0034

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September 2002

Maine Bureau of Insurance
34 State House Station
Augusta ME 04333

Guide to Requesting an Independent External Review When Your Health Insurance Carrier Denies Benefits for Health Care Services

A Publication of the Maine Bureau of Insurance
Consumer Health Care Division

Angus S. King, Jr.
Governor

S. Catherine Longley
Commissioner

Alessandro A. Iuppa
Superintendent

Guide to Requesting an Independent External Review When Your Health Insurance Company or HMO Denies Benefits for Health Care Services

Maine's Patient's Bill of Rights[1] gives patients the right to request an independent external review when a health insurance carrier (insurance company or HMO) denies benefits for health care services. A written request for external review must be filed with the Superintendent of Insurance within 12 months from the date you receive the final notice of decision under your health insurance carrier's internal appeal procedure. This brochure is intended to help you understand your right to request an external review.

[1]Maine Public Law 1999, Chapter 742, *An Act to Establish a Patient's Bill of Rights* enacted Title 24-A M.R.S.A. § 4312 of the Health Plan Improvement Act, giving patients the right to request an independent external review.

1. You may request an external review of certain kinds of health care treatment denials, including:

- Denials involving issues of medical diagnosis, care or treatment.
- Denials involving issues of medical necessity.
- Denials involving issues of preexisting conditions.
- Denial of health care services that the health insurance carrier considers to be experimental or investigational.

2. Before requesting an external review you must either:

- Exhaust the health insurance carrier's first and second level appeal and grievance process,

OR

- Meet the criteria for an expedited review, described below.

3. Written requests for external review should be sent to the Bureau at:

Consumer Health Care Division
Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Please include and sign the
Authorization for Release of Medical Records.
(Found on the last page of this brochure.)

4. When the requested care is URGENT, or a delay in receiving the care could jeopardize your health, you can request an "Expedited Review."

You can request an expedited review if you or your health care provider believe that the timeframe for completion of the health insurance carrier's internal appeal and grievance procedure could result in serious jeopardy to your life or health, or could jeopardize your ability to regain maximum function. If you need to request an expedited review you should send a written request to the Bureau and call the Bureau's Consumer Health Care Division to advise Bureau staff that a request for an expedited review is being sent.

You can also request an expedited review if:

i. The health insurance carrier has failed to issue a written decision on an internal appeal or grievance within the required time periods and the delay is the fault of the insurer.

ii. The health insurance carrier and the enrollee mutually agree to bypass the internal grievance procedure.

iii. An enrollee's representative may request an expedited independent external review if the enrollee has died.

5. What happens when you request an external review?

A. The Bureau will first evaluate your request to determine whether it involves one of the kinds of health care treatment denials described above that qualifies for external review under Maine's Patient's Bill of Rights. This is the only substantive role that the Bureau plays in the external review process.

B. If the Bureau determines that you are entitled to an external review under the statute the Bureau will direct your health insurance carrier to send the one copy of the pertinent medical records for the review to the Bureau's contracted external review organization and one copy of the pertinent medical records to you. You and/or your health care provider will have an opportunity to request additional information from the health insurance carrier and to submit additional information directly to the external review organization. The external review organization will provide your health insurance carrier with copies of any additional information you submit so that everyone concerned will have copies of all records being reviewed.

C. The external review organization will send you and your health insurance carrier a written decision within 30 days after it receives the case for review. An external review decision is binding only on the health insurance carrier. You are not prohibited from filing a legal action against the health insurance carrier if you are dissatisfied with the external review

organization's decision. However, you will not be able to obtain a subsequent external review involving the same denial of benefits.

6. You have a right to participate in the external review if you choose to do so.

You have the right to ask the external review organization to schedule and conduct a hearing, which will typically be held via teleconference. If you do not request a hearing the clinical peer reviewer will render a decision based on the records and information provided by your insurance company, and by you and your health care provider. You should let the Bureau know as soon as possible whether you would like to have the external review organization conduct a hearing. You have the right to submit and obtain supporting material relating to the health insurance carrier's denial of benefits, the right to ask questions of any representative of the carrier, and the right to have outside assistance at the hearing.

7. Maine's external review law does not apply to government or self-insured employee benefits plans.

Under state law you are not entitled to request the Bureau of Insurance for an external review if your health plan is a government or self-insured employee benefits plan. However, you should check with your plan administrator to determine if you have appeal or external review rights under your plan.

If you have additional questions about your right to external review or the external review process please call the Bureau at (800 300-5000 toll-free in Maine) and ask to speak to the Consumer Health Care Division Staff Attorney. You can also reach the Consumer Health Care Division by calling (207) 624-8475.

Authorization for Release of Medical Records

I hereby authorize that any hospital, physician, insurance carrier or insurance carrier subcontractor; or any entity regulated by the Maine Bureau of Insurance may furnish the Bureau and the Independent Review Organization (IRO) assigned to review the insurance carrier's adverse health care treatment decision with any medical information or records that may be required to conduct the external review. I specifically authorize release of information concerning mental health and substance abuse treatment if that information is needed to conduct the external review.

_____

Signature and Date

EXTERNAL REVIEW TELEPHONE CONFERENCE CONTACT SHEET CONSUMER **

Participating Insured Requesting Review:	**Telephone Number and E-Mail Address**	**Available Time and Days:**
Name: _____	_____	_____
Mailing	_____	_____
Address:_____	_____	_____
_____		

Participating Designated Representative:

Name: _____	_____	_____
Mailing	_____	_____
Address:_____	_____	_____
_____		

Participating Insured's Treating Provider:

Name: _____	_____	_____
Mailing	_____	_____
Address:_____	_____	_____
_____		

Additional Comments:

_____

_____

_____

**** Please return this sheet to the Bureau of Insurance 34 State House Station Augusta, ME 04330 ASAP. This information is necessary if you and or your provider want to be represented at the Teleconference hearing.**

MAINE TAX QUALIFIED LONG TERM CARE INSURANCE POLICIES

Starting with Tax Year 2002: New Tax Certification Program For Deducting Long Term Care Insurance Premiums on Maine Income Tax Returns

Maine's history of income tax incentives for long term care insurance premiums is in three stages, the latest may not yet be widely known:

1. Premiums were deductible on individual and corporate Maine tax returns for any long term care (LTC) policy or contract the Superintendent of Insurance, through 1999, certified as eligible for the tax incentives in Title 36 M.R.S.A. §§ 5122 *et seq.* **Once certified**, the policy or contract became and remains entitled to the incentives in all tax years in which the deduction is claimed.

2. Effective January 1, 2000 a new LTC insurance law, Title 24-A M.R.S.A. §§ 5071-80, expanded the range of Maine plans eligible for deduction of paid premiums. Under this law, if a contract is *federally* qualified, **no matter when the qualification occurred**, starting with tax year 2000 it is also Maine qualified. Conversely, federally non-qualified plans are automatically Maine non-qualified. (Adoption of the federal standard does not affect plans certified under the former LTC law. These plans continue their Maine tax eligibility.)

3. The most recent statutory change, Title 24-A M.R.S.A. § 5075-A, makes all post-1999 LTC policies and contracts, not otherwise Maine certified or qualified, eligible for tax incentives. Section 5075-A establishes a new certification program, which allows the insurer to request certification for tax years beginning January 1, 2002, for any plan issued after January 1, 2000.

The process for the insurer to obtain the Superintendent's tax certification letter is simple. Under § 5075-A(3), the plan becomes entitled to tax incentives when the Superintendent certifies in writing that the form complies with the standards and other requirements of Title 24-A M.R.S.A. Chapters 27, 33, 35, and 68-A and Bureau of Insurance Rules, and is certified as an approved LTC policy or contract. Following each certification, the Bureau will transmit a copy of the Superintendent's letter to Maine Revenue Services, with an updated list of certified forms.

The list of all certified plans, pre-2000 and the § 5075-A forms are available on the Bureau's Internet website, *MaineInsuranceReg.org* under *consumer info/health*.

LONG TERM CARE POLICIES CERTIFIED FOR INCOME TAX INCENTIVES IN TAX YEARS BEGINNING JAN. 1, 2002; APPLICABLE TO FORMS APPROVED BY BUREAU OF INSURANCE AFTER JANUARY 1, 2000 (24-A MRSA § 5075-A)

COMPANY	FORM NUMBER	CERTIFIED DATE
Bankers Life and Casualty Co. 222 Merchandise Mart Plaza Chicago IL 60654-9988	GR-N270 GR-N280 GR-N410 GR-N370 GR-N380	10/5/2000 10/5/2000 2/12/2001 6/17/2002 6/17/2002
Mutual Protective Ins. Co. Box 3477 Omaha NE 68103	MP-LT201	

▶New Tax Certification Program For Deducting Long Term Care Insurance Premiums on Maine Income Tax Returns

By Michael Roberts, Contract Examiner, Consumer Health Care Division

Maine's history of income tax incentives for long term care insurance premiums is in three stages. The most recent may not yet be widely known.

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Following each certification, the Bureau transmits a copy of the Superintendent's letter to Maine Revenue Services, together with an updated list of certified forms. The lists of all certified plans, pre-2000 and the § 5075-A forms, are available on the Bureau's Internet website MaineInsuranceReg.org at:
http://www.state.me.us/pfr/ins/ins_consumer_info.htm#health.

Beware of Unlicensed Health and Medicare Supplement Insurers

By Joanne Rawlings-Sekunda, Health Policy Analyst, Consumer HealthCare Division

As the cost of health insurance and Medicare supplement policies continue to rise, a growing number of unauthorized insurers are appearing. These "insurers" market seemingly low-cost plans to small business owners and individuals. They may pay a few of the policyholders' initial claims, then leave them without coverage. The policyholders do not realize they're not covered until they have large medical bills. Moreover, many of these plans – unlike group health insurance and HMO contracts that have been approved by the Bureau – are structured in a way that leaves the employer liable if the insurer fails, or if the insurer refuses to pay valid claims.

Many of the health "insurers" market themselves as ERISA plans, exempt from state regulation. However, a legitimate ERISA plan can only be established by an employer for its employees or by a union for its members. Any insurer that sells insurance to more than one employer is subject to state licensure. Furthermore, when an ERISA plan buys an insurance policy, the insurer is still subject to state regulation – only the employer or union is exempt.

The fraudulent insurers use official-sounding names, often very close to the names of legitimate insurers. Health "insurers" may create fake associations or unions. Medicare supplement "insurers" may choose titles designed to make consumers think their purchase is connected to the government.

These fraudulent companies are operating across the country. The Coalition Against Insurance Fraud conservatively estimates tens of thousands of people in several dozen states have been swindled out of tens of millions of dollars in premiums in the last several years. Florida has ordered the shutdown of six unauthorized insurers in a little over a year and is running a media campaign called "Verify Before You Buy", to make consumers aware of unlicensed companies. Georgia shut down three in three months. Texas shut down four in the past year. Virginia instituted an "Insurance Fraud Awareness Day" to alert consumers.

Here in Maine, the Bureau is currently investigating several possibly fraudulent companies. Whether an entity is actually engaged in the business of insurance is a factual determination for which there is no easy rule to follow. Rather, the various factors developed over the years, such as risk transfer, need to be applied to the facts at hand.

Maine law (M.R.S.A. Title 24-A, §2101) expressly prohibits marketing or selling products of an unlicensed entity. For a list of licensed insurers, check out the "Producer/Business Entity Information" and "Insurance Company Information" sections of the Bureau's website, at www.MaineInsuranceReg.org or call the toll-free number listed above. If you have questions about a particular company, please call the Bureau of Insurance at 207-624-8475.

Florida:

1. Vanguarde Asset Group (based in New York)

2. N.A.P.T. (based in Pennsylvania) -- includes National Association of Professionals & Technicians; National Association of Professional Truckers; National Association of Professional Traders

3. Well America (based in Florida)

4. T.R.G. Marketing Group (based in Indiana)

5. American Benefit Plans (based in Texas) -- see below

6. Employers Mutual, LLC (based in Nevada) -- includes American Benefit Society

Georgia:

1. O.T.R. Truckers Association, Inc. (based in Georgia)

2. Employers Mutual, LLC

3. Uni-Med Health Plan (based in Georgia)

4. Fidelity Group (back in 1999)

Texas:

1. American Benefit Plans (based in Texas) -- includes: United Employers Voluntary Employee Beneficiary Association; National Association for Working Americans; American Association of Agriculture, Forestry and Fishing Workers; American Association of Transportation, Communication, Electrical, Gas and Sanitary Workers; American Association of Wholesale Trade Workers; American Association of Manufacturer Workers; American Association of Service Workers; American Association of Professional Workers; Electronic Benefits Group, Inc.; Enhanced Health Management; The Four Corners Company, LLC

2. Office and Professional Employees International Union (based in Texas) -- includes National Guild of Medical Professionals Health and Welfare Benefit Trust Plan (NGMP) and Solidarity Health Plan (SHP)

3. Employers Mutual, LLC

4. SAI Plus, LLC (based in Maryland)

5. AJAX Health Benefits Plan (based in the Northeast)

Frequently Asked Questions: Health

How much time does the company have to pay my claim?
Regarding health, policy language would dictate a time frame for providers to submit claims. Proof of loss would be required in any disability claim, and a death certificate would be required for claim payments in life policies.

Am I required to provide a recorded statement about the claim?
Keeping good records of encounters is a good idea when dealing with life/health insurance companies in case a claim dispute arises. The more evidence, the better.

What effect will cancellation for nonpayment have on my ability to find coverage in the future?
If this is an individual policy, your insurance company may not be required to give you a new policy for 91 days. If that happens, any health problems that you currently have (called "pre-existing conditions") may not be covered for up to 12 months. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2736-C(3)(A).

Why is the insurance company not returning all of my premium?
A law enacted in 1998 states that life/health contracts must disclose company policy on applications about returning premium and also when you request cancellation of your policy. Also Medicare supplement return premium is at the discretion of the company.

What are the possible effects of concealing information from the insurance company?
You may jeopardize your coverage (a policy cancellation or nonrenewal could result) and payment for claims. Answer all questions honestly, to the best of your ability. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2178, §2179, §2186, and §2187.

I need individual health insurance. What can I do?
Individual health insurance is guaranteed issue in Maine, which means that anyone can get coverage regardless of health. Additionally, rates can't be raised because of health conditions or filing claims.

My insurance company is denying a claim because they say it's a preexisting condition. Can they do that?
When you applied for a health insurance policy, if you did not have coverage for more than 63 (or in some cases 90) days beforehand, it is possible that the insurance company can exclude claims related to a preexisting condition for up to 12 months. However, if you are switching coverage - even from Medicare or MaineCare (formerly Medicaid and CubCare) -- the new company cannot exclude something that was covered under the old policy. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2850.

I don't want my new insurance policy. Can I give it back to the company?
This depends on the type of insurance you bought. Medicare supplement and long term care insurance have a 30-day period during which you can cancel the coverage and have your money refunded. Other products have at least a 10-day "free look" period when you can cancel coverage. The free look provision in your policy should be stated on the front page. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2717, Bureau of Insurance Rule Chapters 191 Section 9 M or 275 Section 7.

I want a Medicare HMO. Can I get this in Maine?
Currently Maine has no carriers that are offering coverage to Medicare beneficiaries. For more information on Medicare HMOs or Medicare supplements, contact your producer or the Bureau.

My medical insurance subjects my doctor's treatment recommendations to Utilization Review. What is Utilization Review?
"Utilization review services" or "medical utilization review services" means a program or process that seeks to review the **utilization, appropriateness or quality** of medical services provided to a person. The terms include these programs or processes whether they apply **prospectively, concurrently, or retrospectively** to medical services. Utilization review services include, **but are not limited to**, the following:

- Second opinion programs.
- Prehospital admission certification.
- Preinpatient service eligibility certification; and
- Concurrent hospital review to determine appropriate length of stay.

When Primary Care Physician (PCP) refers me to a specialist and my health plan approves the referral, I may then see the specialist and my health plan will then provide the greatest benefit level for those approved specialist services. If the specialist refers me to another provider, do I need to notify my PCP or my health plan?
Yes. You must contact your PCP and receive your health plan's authorization before seeing **any** other provider in order to receive the greatest benefit level from your health plan.

How long does it take a health plan to approve or disapprove a referral from my PCP?
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 admission, procedure or service requiring a review determination.

What is an Elimination Period?
The number of days of care that you pay out-of-pocket before the insurance company begins to pay benefits.

Does the Bureau of Insurance determine the rates the insurance company charges for my employer's plan?
No. The Bureau of Insurance approves rates for individual policies, but not for small or large groups. Employers negotiate group rates with the insurance companies. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2808-B(2) and §2736-C (2).

I need to buy health insurance for my family and myself. What can I do?
For information on the companies providing individual insurance policies, along with their premiums, go to: www.state.me.us/pfr/ins/indhlth.htm. You cannot be denied the chance to buy individual insurance, regardless of any health problem you may have, as long as you pay the premium. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2736-C(3).

I don't make much money and I need to get insurance for my family and myself. Where can I go?
The Maine Department of Human Services helps low-income families get coverage through MaineCare (formerly Medicaid and CubCare). For more information, contact them toll-free at 1-877-KIDS-NOW (1-877-543-7669) or www.state.me.us/bms/faq/client_faq.html.

I am thinking about buying health insurance for a short period, six months or one year. What do I need to know about short-term policies?
Short-term policies do not have all the consumer protections available under comprehensive health policies. The most important differences are: preexisting conditions are not covered even if you had prior coverage; the time when you are covered by this policy is not counted as creditable coverage for any individual health insurance you buy later, which can mean you will have to wait an additional year before preexisting conditions will be covered; and you cannot be insured for more than one year with a short-term plan. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2849-B(8).

I was laid off and lost my coverage, but my spouse has coverage through their employer. When do I need to apply to get on that plan?
You must apply within 30 days of losing your coverage; otherwise, you will need to wait until your spouse's employer's plan has open enrollment (typically for one month each year). To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2849-B(3).

I just had a baby. Is she covered under my insurance policy?
Yes, from the moment of birth -- or in the case of an adopted child from the moment the placement papers are signed -- for 31 days. The insurance company may require you to notify them and/or pay an additional premium within that 31 days to continue coverage beyond that point. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2743, §2834 and §4234-C.

I just heard about "ABC Insurance Company" and they have rates much lower than any of the other plans I've seen. Are they a good company?

As the cost of health insurance and Medicare supplement policies continue to rise, a growing number of unauthorized insurers are appearing. These "insurers" market seemingly low-cost plans to small business owners and individuals. They may pay a few of the policyholders' initial claims, then leave them without coverage. The insurance company you're interested in may or may not be one of these fraudulent plans; the only way to know is to check with the Bureau of Insurance by calling 1-800-300-5000. The Bureau cannot recommend companies but can tell you whether the company is authorized to do business in Maine.

Is a discount card considered insurance?

No. Discount cards do just that - provide discounts for health care services or prescription drugs. You have to pay all costs beyond the discount. For example, compare what you'd pay out-of-pocket for a prescription drug that costs $100: If your discount card provides a 25% discount, you have to pay $75; if your insurance policy has a copay, you have to pay much less. A discount card doesn't give you any of the protections of an insurance policy. If you decide to get an insurance policy in the future, any health conditions you have before buying the policy can be excluded from coverage for up to 12 months.

Should I tell the insurance company about my current health problems?

If they ask, yes. In Maine, you cannot be turned down for individual insurance, regardless of any health problems you may have, and you cannot be charged more for those health problems. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2736-C(2-3).

If I cancel my policy before the end of the term, can I get my money back?

If there's nothing in your policy's language about refunds, you will get a full refund for the remaining term if you cancel. If the policy says something about refunds, the policy dictates how much, if anything, you'll get back.

My insurance company says I'm in a self-funded plan. What does that mean?

In a self-funded plan, you employer is responsible for paying your covered health care costs. Claims may be administered by an insurance company, but there is no actual insurance policy involved; therefore, the State of Maine has no jurisdiction. If you have a health-care related problem, check with your employer to see if you're in a self-funded plan. If you are, then call the U.S. Department of Labor toll-free at 1-866-275-7922.

Are there certain benefits my insurance company must provide?

Yes. For individual and group policies, the State mandates certain benefits, including screening mammograms, breast cancer treatment, prostate cancer screening, medical food for inborn errors of metabolism, and chiropractic services. Group policies issued to employers with more than 20 employees must also cover treatment for mental illness, alcoholism and drug dependency. The insurance company may put limits on some of these benefits. For a list of mandated benefits, see: http://www.state.me.us/pfr/ins/mndtsum.htm.

Can I select my obstetrician/gynecologist (OB/GYN) as my primary care provider (PCP)?
You may select a participating OB/GYN as your PCP if he or she has a contract with your insurance company to provide primary care. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2847-F and §4241.

I need to see a certain kind of specialist, and the only one who participates in my insurance company's network is 2 hours away. What can I do?
If there is no participating specialist within a 60-minute drive from your house and there is a closer non-participating specialist, your health plan must allow you to see the non-participating specialist at no greater cost to you than if that specialist did participate in the network. This 60-minute drive maximum also applies to hospitals; for primary care physicians, the maximum is a 30-minute drive. To see exactly what Maine law says on this issue, see: Bureau of Insurance Rule Chapter 850, Section 7.

My medical insurance subjects my doctor's treatment recommendations to utilization review. What is it?
Utilization review is a program or process that seeks to review the utilization, appropriateness or quality of medical services provided. This can be done before, during or after the service is provided. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §4304 or Bureau of Insurance Rule Chapter 850 Section 8.

How long should it take my health plan to approve or disapprove a requested service (referral) from my primary care physician (PCP)?
For initial determinations, the health plan should let you and your PCP know of their decision within 2 working days of obtaining all necessary information. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. § 4304 (2) or Bureau of Insurance Rule Chapter 850, Section 8(E).

If I go to a specialist after receiving approval from my health plan for the referral, and the specialist then refers me to another provider, do I need to notify my primary care provider (PCP) or my health plan to get another referral?
If you are in a managed care plan that requires referrals, yes. You must contact your PCP and receive your health plan's authorization before seeing any other provider in order to receive the greatest benefit level from your health plan.

How much time does the health insurance company have to pay my claim?
Undisputed claims are payable within 30 days of the insurance company receiving the claim from the provider. If the insurance company does not pay within 30 days, it must pay interest. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §2436.

I'm covered by 2 health insurance policies. If I have a claim, who pays first?
"Coordination of benefits" is the way 2 or more health plans coordinate their respective benefits so that the total benefit paid is not more than 100% of the charges. Maine does not have rules governing coordination of benefits, but the typical process is as follows:

(1) If you are an active employee, the plan that covers you as an employee is primary (pays first) over the plan that covers you as a dependent, laid-off employee, retiree, or COBRA-covered person.
(2) If you and your spouse are not divorced or separated, the primary plan for your dependent children is the plan covering the parent whose birthday falls earlier in the calendar year.
(3) If you and your (former) spouse are divorced or separated, the claims for your dependent children are paid in the following order (unless mandated by a court order): first, by the plan of the parent with custody; second, by the plan of the spouse of the parent with custody; third, by the plan of the parent without custody. If the parents have joint custody, the birthday rule applies.

My doctor sent me a bill for what my insurance company didn't pay. Is that OK?
In managed care, whether your doctor can "balance bill" depends on whether he/she participates in your insurance company's network. Doctors who do participate in the network cannot bill for the balance between their charge and what the insurance companies pay, except for limited copays; doctors who do not participate in the network can charge their regular fee. However, if you're seeing a non-participating doctor because there are no participating doctors within your area (see the question above on specialists), then you cannot be balance billed. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §4204 (6).

Medicare Supplement Insurance

I will be turning 65 in a few weeks. Can you please explain the open enrollment for Medicare supplement (Medigap) insurance policies?
If you are turning 65, your first priority is to make sure you are enrolled in Medicare Part B (contact the Social Security Administration at 1-800-772-1213 or www.ssa.gov for information on enrollment procedures). Federal law gives you a 6-month "open enrollment" period to apply for a Medicare supplement insurance policy, beginning with the first month that you enroll for benefits under Medicare Part B. For information on available Medicare supplement plans, see: www.state.me.us/pfr/ins/medicare.htm. To see exactly what Maine law says on this issue, check out: Bureau of Insurance Rule 275 Section 11. For other questions about Medicare or Medicare Supplement policies, contact the Maine State Health Insurance Assistance Program at 1-800-262-2232 (within the state) or www.state.me.us/dhs/beas/hiap/welcome.htm.

I want a Medicare HMO. Can I get this in Maine?
Currently Maine has no carriers offering HMO coverage to Medicare beneficiaries. For information on Medicare supplement plans, see: www.state.me.us/pfr/ins/medicare.htm. For other questions about Medicare or Medicare supplement policies, contact the Maine State Health Insurance Assistance Program at 1-800-262-2232 (within the state) or www.state.me.us/dhs/beas/hiap/welcome.htm.

Can I change from one Medicare supplement plan to another?
If you have had a Medicare supplement plan since you turned 65, in most cases you can change to the same or a lower plan (e.g., from plan "G" to plan "A") at another company without having to wait for open enrollment. However, you must obtain your new plan within 90 days of leaving the old plan. To see exactly what Maine law says on this issue, see: Title 24-A M.R.S.A. §5002-B. For other questions about Medicare or Medicare supplement policies, contact the Maine State Health Insurance Assistance Program at 1-800-262-2232 (within the state) or www.state.me.us/dhs/beas/hiap/welcome.htm.

Long Term Care Insurance

When can I deduct long term care premiums on my Maine income tax return?
Premiums for federally tax-qualified long term care policies are now deductible on both Maine and federal returns. However, the federal tax deduction will benefit you only if you have medical expenses exceeding 7½% of your income. The policy itself will inform you whether it is federally or Maine tax-qualified. Premiums for non-qualified policies, whenever issued, are deductible on Maine returns only if the policy form has been certified by the Superintendent of Insurance and reported to Maine Revenue Services. For more information, see: www.state.me.us/pfr/ins/ltc_tax_qualified.htm.

Is there a difference in benefits payable under tax-qualified versus non-qualified long term care policies?
No. Benefits are the same for both, but there are differences in the policy "benefit triggers." Triggers involve the medical or mental condition which dictates whether benefits are payable. Benefits are generally triggered more easily for a non-qualified policy; however, the premium for this kind of policy often is higher than for a tax-qualified plan. For more information, see: www.state.me.us/pfr/ins/ltc_tax_qualified.htm.

I took the Long Term Care deduction on my State of Maine Income Tax and was notified that my policy was not certified and the deduction could not be used. Why?
You do not have a "Long Term Care" policy as defined in Maine law, 24-A MRSA Chapter 68. In order for a policy to be certified by the Superintendent as a Long Term Care Policy, the policy must cover **both** nursing home confinements and home health care.