Bureau of Insurance Consumer Health Care Division
Annual Report to the Legislature for the Year 2003

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I. Overview

This report is being issued pursuant to 24-A M.R.S.A. §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 fifth year of operation, focuses its efforts on consumer assistance, outreach, and oversight of insurer compliance with the Insurance Code (Title 24-A) and Bureau regulations.

The Division is responsible for the following activities:

- Review and approval of health insurance forms (Policy Language) ,
- Investigation and resolution of consumer health insurance complaints,
- License Approvals for medical utilization review entities (UREs),
- Review and approval of long-term care insurance forms,
- Oversight of the Bureau's external review process,
- Drafting and review of health insurance regulations,
- Bringing enforcement actions against health insurance carriers and other licensed entities when violations occur,
- Review of managed care plans for compliance with provider network adequacy measures,
- Approving the licenses for preferred provider arrangements (PPOs),
- Developing outreach and educational materials,
- Drafting reports on issues involving health policy,
- Participating on the Interagency Task Force for the Quality Oversight of Commercial Health Maintenance Organizations (HMOs),
- Tracking, trending, and analyzing data,
- Responding to consumer inquiries through the toll-free Consumer Assistance Hotline (800-300-5000), Email and one on one conferences,
- 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 including other state agencies,
- 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.

"Thank you for your investigation of my complaint and concern. This has helped clarify the transaction terms that were otherwise unclear to me. I have been a [carrier] client for many years and my appreciation of [carriers] fine services will continue. I cannot thank you enough for the superb service provided on my behalf by the State of Maine." *Consumer*

II. Accomplishments

A. Consumer Assistance

- **Inquiries**

CHCD staff responded to 6,449 telephone inquiries during 2003. The most frequent inquiries related to:

- Medicare Supplement insurance
- Individual insurance
- Claim denials
- Long Term Care.

"Thanks very much for your friendly, informative help. I will speak to our accountant and get back to you with any questions." ...*Consumer*

The CHCD staff responded to over 30 requests for consumer assistance from state and federal legislative officials who had been contacted by constituents. Like the telephone inquiries, these requests for assistance on behalf of constituents encompass a wide range of health insurance related issues.

Staff 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, consumers are referred to the appropriate agency, 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). Many times, CHCD staff can contact the carriers to get immediate resolution or to expedite the appeals process.

"I just want to express my appreciation for your assistance in the matter of consumer. ...I feel very fortunate that I was able to have this issue resolved so quickly. I keep thinking of all the elderly that fall through the cracks and have no one to speak on their behalf.." ...Consumer

- **Complaints**

During 2003, the CHCD responded to 671 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. 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 CHCD requests that enrollees sign a consumer complaint form authorizing the CHCD staff to contact insurance company and health care providers in order to resolve the dispute.

Often the complaint is with an employer or company not within the Bureau's jurisdiction. In those instances the complaint is forwarded to the regulatory agency with jurisdiction to investigate and enforce the provisions of the health insurance contract.

In conducting complaint investigation the carrier is directed to respond to the allegations and determine if errors were made by the company. The insurance carrier response and supporting documentation are reviewed by CHCD staff to determine if the processes used by the carrier complies with the terms of the insurance policy, as well as Maine law and regulations. The enrollee is kept informed of the progress of the investigation and at times is requested to provide additional information.

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. CHCD staff have been able to resolve some of those situations immediately when it is evident that the carrier's denial is flawed or contrary to specific requirements in the consumer's insurance policy or contained in Maine law. During 2003 the CHCD staff was instrumental in assisting with the recovery of $667,501 for enrollees and policyholders. Most often, the recovered funds are from previously denied claims.

"Thanks again for your advice on how to proceed with this. You do good work, and it certainly is necessary to have your department to control these people. All the best. ."
...Consumer

Frequently the staff is able to assist consumers in achieving their desired results; however, there are instances when the Bureau is unable to assist the enrollee or policyholder to their satisfaction. There are also instances when CHCD staff must explain the basis and rationale for the carrier's decision and to inform enrollees that the carrier has not violated Maine law. 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 when federal law takes precedent, however, staff take the opportunity to provide the consumer with information 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 customer relations coordinator for the carrier called me this week to report that my father's cancelled policy has been reinstated. I attribute this success in great part to your intervention in my father's problem with [carrier]. Thank you, and thanks to the Maine Bureau of Insurance for providing an impartial intermediary when appeals to insurance companies do not provide satisfaction. ."
...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. Despite these preventative measures the Superintendent entered into several consent agreements with carriers and issued one letter of reprimand in 2003 stemming from consumer complaints received and investigated by CHCD. Investigations and enforcement actions CHCD provided a basis for the market conduct examinations that found prompt payment violations by Anthem Blue Cross and Blue Shield of Maine and CIGNA HealthCare. The market conduct examinations resulted in penalties of $353,000 and $900,000 These fines represented the most ever assessed by the Bureau. Additionally, millions of dollars in restitution were paid to enrollees and providers. The consent agreements and the letter of reprimand are available on the Bureau of Insurance webpage.

"I don't often write letters like this but you folks threw out a life preserver when everyone else turned their backs on my problem. Thank you and rest assured you have at least one cheerleader in your efforts to protect the people of the state of Maine from the arrogance of large insurance companies...."*...Consumer*

In the CHCD's analysis of the consumer complaints and inquiries, two trends emerged:

- Maine residents contacted the CHCD in search of affordable health insurance coverage;

- Many residents who contact the CHCD are often times confused about their benefits, and the steps they must take to receive the maximum benefits under their policy.

- **Outreach and Education**

One of the principal objectives of the CHCD is to educate consumers how to advocate for themselves so they are comfortable with the system and aware of their rights. The CHCD encourages communication between carriers and providers during outreach activities.

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

- Living with Cancer Conference;
- Cancer Community Center – South Portland;
- Society of Financial Examiners;
- Bath Senior Citizens Center workshop;
- Public Forums in Ellsworth, Presque Isle and South Portland
- Bureau of Elder and Adult Services Regional Coordinators; and
- Health Insurance Partnership (National Panel).

Due to his conscientious advocacy, Mike obtained positive results from both insurers. Mike is an asset to state government. His diligence and understanding continue to be much appreciated."…Consumer

In 2003, the CHCD initiated consumer outreach program that will include a visit to each of Maine's 16 counties each year. The CHCD's first county outreach meeting was held in Androscoggin County at the Lewiston Public Library on December 18, 2003. The CHCD staff developed new educational materials and presentations to provide interested consumers when visiting each community. A sample of the advertising for this outreach is listed in the Appendices at the end of this report.

CHCD staff also provides information to consumers by developing written educational materials, both for the website and hard-copy distribution. These materials, found in the Appendices 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;

- "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.
- What Should I Look for When I Buy Health Insurance?", http://www.state.me.us/pfr/ins/choose%20health%20ins.htm, including helpful tips for consumers looking to purchase policies.
- "The Maine Bureau of Insurance Consumer Health Care Division"

"I cannot thank you enough for your guidance & professionalism and efficiency in handling my insurance fiasco. It was reassuring & comforting to know there was someone who could help me, and was so willing to do so. We need more people like you working on our behalf in all sectors of government. Many, many thanks. ... 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

Policyholders and enrollees have the right to request an external review when a health insurance carrier or HMO denies benefits for medically necessary health care services after exhausting their internal appeals process established by their insurance company or HMO. It is an "external" review because a contracted review organization which has no affiliation with the insurance carrier conducts the review. The decision of the external review is binding only on the carrier, while policyholders and enrollees can seek private legal action if they choose.

The Bureau contracted with three independent external review organizations for 2003 and 2004, The Center for Health Dispute Resolution, Hayes Plus, and Prest Associates. (Because of conflicts of interest, in 2003 the Bureau was unable to place any external review cases with Prest Associates.)

The Bureau processed 25 qualified requests for external review during 2003. Of these cases, 22 reviews were completed with the following results: nine (41%) were completely overturned (the carrier's original decision to deny coverage was entirely reversed), three (14%) were partially overturned (only part of the claim denial was reversed), and ten (45%) were upheld (Of the three remaining qualified reviews, prior to the hearing the carrier withdrew one and the consumer withdrew the others.

The CHCD received five requests for external review that did not qualify as eligible under the statute, either because the consumer had not exhausted both levels of the insurance carrier's internal appeal process or because the denial was based on issues other than validity of the carrier's medical decisions.

The Consumer Health Care Division has prepared an informational brochure called *Guide to Requesting an Independent External Review,* which is included in the attachments.

"Just a note to express my thanks for your effort and success with my recent insurance complaint. I am seeing evidence that [carrier] has begun to make payments on the claims for February. It certainly means a great deal to know that we as consumers do have good, caring capable people working on our behalf! *Respectfully,...Consumer*

C. Licensing Activity

At the end of 2003, there were seventy-three (73) medical utilization review entities (UREs) licensed in Maine. Applicants must certify compliance with Maine's UR requirements, 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 *Producer/Business Entity Information*.

The CHCD policy development specialist reviews and registers preferred provider arrangements (PPAs). In addition to the 20 PPAs previously registered, seven new arrangements were registered in 2003. Preferred provider arrangements are reviewed for compliance with Maine statutes regarding: accessibility, utilization review, grievance and appeal procedures, provider compensation, consumer notification, and emergency access requirements. 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 Maine law and regulation. HMO applications to expand their 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 apprised 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 alternative providers and to make sure that continuity of care for enrollees currently receiving medical services is addressed by the carrier.

" Thank you for all of your help so far. I really appreciate it. I don't know what I would have done. Thanks."... 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 (PFR), the Bureau of Insurance, and the Department of Human Services (DHS), Bureau of Medical Services. In August 1998, PFR and DHS 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...." To implement this goal, the Inter-Agency Task Force (IATF) for HMO Quality was established by PFR and DHS to perform joint agency functions as set by the memorandum of understanding.

Each year pursuant to 24-A M.R.S.A. § 4215, the IATF notifies each HMO to be examined that the Bureau of Insurance and DHS will conduct a coordinated, on-site State examination of the quality of the carrier's health care and customer services. The CHCD director chairs the IATF, and its policy development specialist heads the examination team. To minimize duplication of time and resources, IATF 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 those operating in Maine, currently participate.)

In 2003, the IATF examination team consisted of:

- Joanne Rawlings-Sekunda, M.P.P., Policy Development Specialist, Bureau of Insurance
- Diane Williams, R.N., C.I.C., C.P.H.Q., Nurse Consultant, Bureau of Insurance
- Joan Lancaster, R.N., Bureau of Medical Services, Department of Human Services (DHS)
- Lillian Phillips, R.N., Bureau of Medical Services, Department of Human Services (DHS)
- Margaret Ross, R.N., consultant, former Director of DHS's Surveillance Utilization Review Services

One of the original members of the state exam team could no longer participate, and three new members joined. An orientation was held in October in order to familiarize these new member with the examination process.

The State exam team conducts HMO examinations using a two-part process.

- First, the team observes the on-site National Committee for Quality Assurance (NCQA) accreditation review. Once the team receives a copy of the HMO's NCQA accreditation report 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. The team then develops a report of its findings.

In 2003, the IATF conducted a quality review activities of two HMOs doing business in Maine:

- Harvard Pilgrim Health Care, Inc. (HPHC) In late June – early July, the State exam team observed HPHC's three-day NCQA reaccreditation survey. In October, after receiving and analyzing the NCQA accreditation report, the team returned to HPHC to target specific areas in Maine statutes and regulations not covered by the NCQA review. A report was prepared, circulated internally, then submitted to HPHC. HPHC submitted its responses to the IATF, correcting several minor problems uncovered by the State survey.

- Aetna Healthcare, Inc. In December, the State exam team observed Aetna's three-day NCQA reaccreditation survey. The team is currently awaiting NCQA's accreditation report.

Harvard Pilgrim Health Care was the last HMO examined by the IATF in its first round of surveys (Aetna, CIGNA, Anthem Blue Cross and Blue Shield, and Maine Partners were previously examined). Before beginning the next round of surveys, members of the IATF met to consider past practices and to consider future improvements of the examination process. As a result the data collection tool used by the exam team is being updated to comply with the latest changes to Bureau regulations. The IATF has engaged the Muskie School of Public Service at the University of Southern Maine to assist with this effort.

Advisory Council

The Consumer Health Care Advisory Council (CHCAC) reviews the work of the Consumer Health Care Division and makes recommendations for improving the division's outreach and operations.

The Council, which consists of nine voting and two ex-officio members, did not meet during 2003. The terms of most Advisory Council members expired in March 2003, and no subsequent appointments were

made resulting in the lack of a quorum for meetings. The current membership of the CHCAC is as follows:

- Senator Lloyd LaFountain, Senate Chair of the Joint Legislative Committee on Insurance & Financial Services
- Representative Christopher P. O'Neil, House Chair of the Joint Legislative Committee on Insurance and Financial Services
- Jeff Baker, Sabre Yachts
- Christine Zukas-Lessard, Acting Director of the Bureau of Medical Services (ex-officio)
- Commissioner, Robert E. Murray, Jr. Department of Professional & Financial Regulation (ex-officio)
- Six Open Positions

III. Policy Form Review

During 2003, the CHCD approved 1,519 policy form filings and disapproved 191 policy form filings. The CHCD receives form filings both in paper and electronic format. The average turn around time for a paper filing was approximately 25 days.

Electronic filings were submitted via the System for Electronic Rate and Form Filings (SERFF). SERFF is a nationwide system developed by the National Association of Insurance Commissioners (NAIC). SERFF filings are given top priority by the Bureau review; the average turn around time for these filings was15 days.

In December, Patricia Libby, CHCD Senior Insurance Analyst, was elected to the national SERFF Board of Directors for a three-year term.

The CHCD adopted and began using several nationally recognized speed-to-market initiatives this year.

- Implemented the National Association of Insurance Commissioners Best Practices Checklists for form review and published it on our website, as well as linking it to SERFF and the NAIC web pages.
- Implemented the use of the uniform transmittal form for paper and SERFF filings
- Implemented the uniform product coding metrics for all paper and SERFF filings. This provides for uniform codes to be used by all states for all lines of business.
- Implemented the use of Electronic Funds Transfer (EFT) for SERFF filings, which enables carriers to submit filing fees electronically rather than by mail.

In 2003 the CHCD began scanning and placing all paper filings into SERFF, allowing one venue for storing and tracking all filings, paper and electronic.

IV. Legislative and Regulatory Activities

The 121st 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.

P.L. 2003, ch. 469, *"An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs,"* is a major initiative addressing access, quality and cost. This report

focuses on the insurance-related aspects of the Dirigo Health plan. A more complete summary, including provisions relating to Medicaid expansion, quality initiatives, disclosure of health care pricing, expanded certificate-of-need requirements, and other cost containment measures can be found at http://www.maine.gov/governor/baldacci/healthpolicy/reform_proposals/summary.htm.

Dirigo Health

A new state agency called "Dirigo Health" will contract with one or more private insurers to offer coverage to small employers and individuals beginning July 1, 2004. Premium subsidies will be provided to individuals and families below 300% of the Federal Poverty Level. Funding for the first year will come from one-time federal fiscal relief money, as well as from federal Medicaid funds for those who are eligible for MaineCare. Funding in later years will come from "savings offset payments" by insurers and third-party administrators. These payments will reflect demonstrated savings resulting from reductions in bad debt and charity care due to increased insurance coverage. The savings offset payments cannot exceed the demonstrated savings and are capped at 4% of premium.

Rule 850 Changes

Rule 850 has limited the ability of insurers to provide financial incentives for covered persons to use designated providers within a network if those providers are not within the maximum distances specified by the Rule's travel standards. The new law allows such financial incentives under the following conditions:

- The overall network must meet the access standards of Rule 850.
- The benefits available to covered persons who do not choose to travel to use designated providers must be consistent with the HMO product design guidelines in Rule 750.
- The financial incentives cannot apply to primary, preventive, maternity, obstetrical, ancillary or emergency care services.
- The carrier must establish to the satisfaction of the Superintendent of Insurance that the financial provisions permit the provision of better quality services and that the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services, or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services.
- The travel distance and travel time to reach a designated provider cannot be more than twice what an insurer may require under the standards established in Rule 850.

To comply with the statute, the Bureau contracted the Muskie School of Public Service (University of Southern Maine) to assist with the development of criteria to evaluate carriers' compliance with the quality standards in Rule 850. Muskie's report - *Identifying Designated Providers Under Rule Chapter 850 Access Standards: A Proposed Approach* – can be found at the Bureau's website.

Subsequently the Bureau proposed amendments to Rule 850 and held two public hearings in November. As a major substantive rule change, the provisionally adopted Rule will go before the Insurance and Financial Services Committee in 2004.

Other Insurance-Related Aspects of P.L. 2003, ch. 469:

- Electronic claims submission -- The new law requires health care practitioners to submit claims to health insurers in electronic format beginning October 16, 2005. Until October 16, 2005, health care practitioners with fewer than ten full-time equivalent employees are not required to submit claims

electronically. After that date, those practitioners may apply to the Superintendent for an exemption from the electronic claims filing requirement.

- Small group rate regulation -- The law provides for increased regulatory oversight of small group insurance rates beginning July 1, 2004. Rates must be filed with the Bureau at least 60 days before they take effect. The process of amending Rule 940 was initiated and is expected to be completed by early 2004.

- Large group rate certification -- Large group carriers will be required to file an annual actuarial certification that their rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by the Actuarial Standards Board. The draft Rule can be found at http://www.state.me.us/pfr/ins/rule940.htm.

- Annual report supplement -- The Superintendent must adopt rules requiring health insurers to file an annual report supplement to provide the public with general, understandable and comparable financial information relative to insurers' in-state operations and results.

P.L. 2003, ch. 20 (LD 1319) An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds, and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2004 and June 30, 2005 – Part VV Effective October 1, 2003

Part VV of this law amends the mental health mandate. Among other changes, it requires parity (benefits equal to those for physical illness) for an expanded list of diagnoses.

Group contracts, other than those covering employers with 20 or fewer employees, must provide, at a minimum, benefits equal to those for physical illnesses for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual (DSM), except for those that are designated as "V" codes by the DSM:

(1) Psychotic disorders, including schizophrenia;
(2) Dissociative disorders;
(3) Mood disorders;
(4) Anxiety disorders;
(5) Personality disorders;
(6) Paraphilias;
(7) Attention deficit and disruptive behavior disorders;
(8) Pervasive developmental disorders;
(9) Tic disorders;
(10) Eating disorders, including bulimia and anorexia; and
(11) Substance abuse-related disorders.
Note: The ICD-9-CM codes associated with these categories can be found in the DSM-IV Classification Section (pages 13-24).

Other new provisions added to the mental health parity mandate include:

- If coverage for physical illness is provided on an expense-incurred basis, the coverage for mental illness may be delivered separately under a managed care system.

- A policy may not have separate maximums, deductibles, coinsurance or limits for physical illnesses and listed mental illnesses. The plan may not impose a limitation on coverage for listed mental illnesses unless that same limitation is also imposed on the coverage for physical illnesses.
- If the policy requires coinsurance for physical illness but instead requires copayments for mental illness, the copayments required for coverage of listed mental illnesses must be actuarially equivalent to the coinsurance requirements for coverage of a physical illness.
- A medication management visit associated with a listed mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits.

For mental illnesses other than those listed, the mandate requires coverage of medically necessary health care and now includes home health care services. Home health care services are defined as services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if hospitalization or confinement in a residential treatment facility would otherwise have been required. The services must be prescribed in writing by a physician or psychologist. Hospitalization can not be required as an antecedent.

The new requirements do not apply to individual coverage or to employers with 20 or fewer employees. The mandated offer for individuals and employers with 20 or fewer employees has not changed.

P.L. 2003, ch. 65 (LD 563) An Act to Require that Mental Health Workers with LCPC Licenses Are Recognized as Licensed Professionals for Purposes of Insurance Reimbursement - Effective January 1, 2004

Health care plans will be required to reimburse licensed clinical professional counselors for mental health services to the extent that the same services would be covered if performed by a physician. A licensed clinical professional counselor is defined as one licensed for the independent practice of counseling who has at least a masters degree in counseling from an accredited educational institution, has been employed in counseling for at least two years, and is licensed as a clinical professional counselor in Maine.

P.L. 2003, ch. 459 (LD 125) An Act to Promote Fairness and Opportunity for Working Amputees - Effective January 1, 2004

Health care plans must provide, at a minimum, coverage for prosthetic devices to replace, in whole or in part, an arm or leg to the extent that they are covered under the Medicare program (currently $100 deductible, 80% coinsurance). Coverage for repair or replacement of a prosthetic device must also be included. Coverage is not required for devices that contain a microprocessor or that are designed exclusively for athletic purposes.

P.L. 2003, ch. 55 (LD 903) Resolve, Regarding Consumer Information for Medicare Beneficiaries - Effective September 13, 2003

This Resolve directs the Department of Human Services and the Bureau of Insurance to work with a statewide organization that provides legal services for the elderly and other consumer advocates. These organizations will develop procedures to ensure that Medicare beneficiaries who enroll in or terminate from the MaineCare program (Medicaid), or MaineCare's qualified Medicare beneficiary program, are informed about consumer protections and options regarding Medicare supplement policies.

P.L. 2003, ch. 108 (LD 423) An Act to Improve the Process of Credentialing Health Care Providers - Effective September 13, 2003

This law sets a time line for provider credentialing by health insurance carriers. It requires carriers to make credentialing decisions within 60 days after receiving a completed application from a provider.

P.L. 2003, ch. 110 (LD 316) An Act to Prohibit Absolute Discretion Clauses in Health Carrier and Excess Loss Carrier Contracts - Effective September 13, 2003
Carriers are prohibited from including or enforcing absolute discretion provisions in health plan contracts, certificates, or agreements.

P.L. 2003, ch. 156 (LD 905) An Act to Protect Employees if Their Employer Fails To Pay Premiums for Employer-sponsored Health Insurance - Effective September 13, 2003
This law requires insurers, prior to cancellation of a group policy, to notify certificate holders at their last known home address. The law also requires that the notice include information on the availability of individual coverage after the group policy is cancelled. These requirements were further modified by P.L. 2003, chapter 428 (LD 1507), described below.

P.L. 2003, ch. 157 (LD 902) An Act to Create Equality in Medicare Supplement Insurance Policies - Effective September 13, 2003
Consumers who have maintained continuous coverage that supplements Medicare (whether Medicare supplement or other types of health plans that supplement Medicare) and who apply for a new Medicare supplement policy cannot be subject to medical underwriting or preexisting condition exclusions to the extent that benefits would have been payable under the prior policy. It also clarifies that persons under age 65 who are eligible for Medicare due to disability have the same Medicare supplement guaranteed issue rights as persons over age 65 who are eligible for Medicare due to age.

P.L. 2003, ch. 218 (LD 897) An Act Concerning Health Insurance Reimbursement and Contracting Practices - Effective September 13, 2003
Health carriers must give providers 60 days notice of substantive amendments to provider agreements. The notice requirement may be waived by mutual agreement. This law also limits the ability of health insurers to impose retrospective denials of previously paid claims to 18 months after the date of payment with certain exceptions. Carriers will be permitted to refuse to accept claims not submitted on standardized claim forms approved by the federal government. The new law also permits the Superintendent to adopt rules that set a minimum amount of interest payable to health care providers pursuant to the statute requiring health insurers to pay interest if an "undisputed claim" is not paid within 30 days of submission. Provisions relating to electronic claims submission were superseded by P.L. 2003, chapter 469 (LD 1611), described above.

P.L. 2003, ch. 313 (LD 1058) An Act To Extend Public Record Requirements of Nongroup Health Insurance Rate Filings to All Health Insurance Rate Filings - Effective September 13, 2003
This law was superseded by the small group rate filing provisions of P.L. 2003, chapter 469 (LD 1611), described above.

P.L. 2003, ch. 321 (LD 1438) An Act To Require Disclosure of Benefit Offsets under Disability Insurance Policies - Effective September 13, 2003
Insurers must provide a clear notice of any benefit offsets contained in disability income insurance policies. For individual policies, the notice must be provided to a prospective buyer at or before the time of application. For group policies, the notice must appear in any enrollment materials and certificates of coverage that are developed by the insurer and are intended to be distributed to enrollees under the group policy.

P.L. 2003, ch. 428 (LD 1507) An Act To Clarify and Update the Laws and Rules Related to Health Care - Effective September 13, 2003

This law has several parts. Some are merely technical corrections to the statutes. The substantive provisions are as follow:

- Small group and individual health insurance carriers can make minor policy changes at renewal with the Superintendent's approval as long as the carrier gives 60 days notice to policyholders and insureds. Previously, any change was considered a replacement requiring six months notice and a finding by the Superintendent that the changes were in the best interest of policyholders.
- The law expands the notice requirements for terminating group health insurance. The requirements will now also apply to dental insurance and will apply to termination for reasons other than nonpayment of premium. The new law also requires that a notice be sent to the employee's last known home address and that the notice include information on the availability of individual coverage.
- Entities that administer employee benefit excess insurance must be licensed as third-party administrators.
- The law clarifies that the requirement for health carriers to provide experience data to large groups applies with respect to former policyholders as well as current policyholders.
- The law repeals the provision that makes long-term care insurance rates effective for only three years.
- The law clarifies what group health insurance rate information has to be filed with the Bureau.
- The law further clarifies that the rate filing requirements for individual health insurance apply to association group coverage that falls within the definition of an individual health plan.

V. Analysis[1]

The CHCD uses the knowledge gained in its work, including consumer complaint reviews and inquiries, to identify complaint patterns and carrier-specific complaint trends. When the CHCD identifies complaint trends, they notify carriers through both formal and informal communications.

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 needs 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.

[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..."

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 inpatient care accounts for about 14% of these cost increases and outpatient care accounts for an additional 37%; services provided by doctors or other health care professionals account for another 27%. Prescription drugs account for about 22%, but are rising rapidly. [2] Other costs include: more expensive medical technologies, administrative costs, and privately insured people subsidizing underpayments by Medicare and Medicaid.

If you are interested in additional information 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.

"It took many calls and letters only to frustrate me with my insurance carrier, but it only took one letter to you folks to change their minds and pay my providers. Thanks Again and may your holidays be a great one!" Consumer

[2] Milliman USA Health Cost Index ($0 deductible), Business & Health Institute August 12, 2003.

Appendices

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

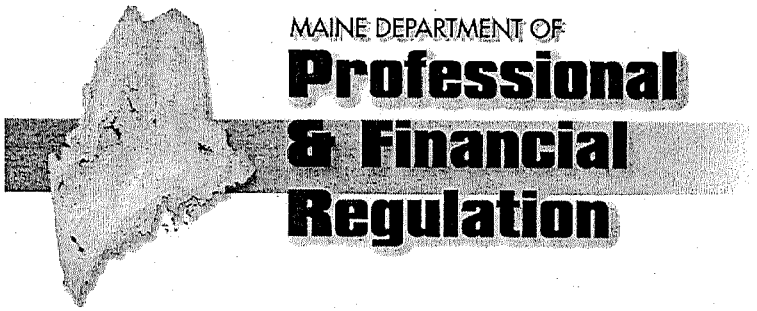
Guide to Requesting an Independent External Review When Your Health Insurance Carrier Denies Benefits for Health Care Services

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

Frequently Asked Questions: Health

What Should I Look for When I Buy Health Insurance?



A Consumer's Guide to...

Health Insurers Doing Business in Maine

(Information for the Year 2003)

John Elias Baldacci, 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 2003 through December 2003.

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 5, 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 efficacy, 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 2003 - December 2003)

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.	53,787	141	16 11%
Anthem Blue Cross & Blue Shield of Maine	67,437	1,231	597 48%
CIGNA HealthCare of Maine, Inc.	26,541	849	345 41%
Connecticut General Life Insurance Co.	86,418	198	95 48%
Guardian Life Insurance Co of America	844	4	0 0
Harvard Pilgrim Health Care	2,148	42	24 57%
John Alden Life Insurance Company	2,781	56	18 32%
Maine Partners Health Plan	30,362	220	95 43%
MEGA Life & Health Insurance Company	13,561	1	1 100%
Patriot Mutual (Dental Coverage Only)	18,346	30*	0 0
United Healthcare Insurance Company	23,284	22	5 23%

*Complaints were adjustments to claims.

COMPLAINT RANKING The chart below shows the companies' complaint standing based on health insurance complaints that were received by the Bureau of Insurance in 2003.

A Complaint Index of 1 (1.0) is average, less than 1 (.9 to 0)is better than average, greater than 1 (1.1 and above)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. 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)	2003 Complaints	2003 Written Premium in Maine	2003 Complaint Index
Aetna Group	95	$171,877,643	1.6
Anthem Insurance Company Group	179	$871,637,333	0.6
CIGNA Health Group	100	$120,914,529	2.3
Connecticut General Life Insurance Company (CIGNA Health Group)	Included in CIGNA's information above		
Guardian Life Insurance Company of America (Guardian Grp)	1	$6,210,878	.9
Harvard Community Health Plan Group	15	$7,619,563	5.5
John Alden Life Insurance Company (Assurant Inc. Group)	13	$11,124,088	3.3
Maine Partners Health Plan (Anthem Group)	Included in Anthem Blue Cross & Blue Shield above		
Patriot Mutual Insurance Company (Dental)	2	$6,750,364	.4
UICI Group (Includes MEGA Life & Health Insurance Company)	23	$26,709,480	2.4
United Healthcare Insurance Group	1	$44,008,183	0.1

AETNA GROUP
AETNA LIFE INSURANCE COMPANY
AETNA HEALTH INC ME CORP

ANTHEM INSURANCE COMPANY GROUP
ANTHEM HEALTH PLANS OF ME INC
ANTHEM LIFE INSURANCE COMPANY
MAINE PARTNERS HEALTH PLAN, INC

ASSURANT INC GROUP
AMERICAN BANKERS INSURANCE COMPANY OF FL
AMERICAN BANKERS LIFE ASSURANCE COMPANY OF FL
FORTIS BENEFITS INSURANCE COMPANY
FORTIS INSURANCE COMPANY
JOHN ALDEN LIFE INSURANCE COMPANY

CIGNA HEALTH GROUP
CIGNA HEALTHCARE OF ME INC
CONNECTICUT GENERAL LIFE INSURANCE COMPANY
LIFE INSURANCE COMPANY OF NORTH AMERICA

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

UICI GROUP
CHESAPEAKE LIFE INSURANCE COMPANY
MEGA LIFE & HEALTH INSURANCE COMPANY

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 in favor of the covered person.

Initial (First-Time) Utilization Review Requests, Decisions, and Appeals (January 2003 - December 2003)

Insurer/HMO	Number of First Time UR Requests Made to the Insurer/HMO	Number of Decisions Insurer/HMO Made to Deny First Time Requests for Services for the Covered Person	Number of Decisions Made to Deny First-Time Requests for Services that were Appealed by the Covered Person	Number of First-Time UR Denials that were Reversed by the Insurer/HMO when the Covered Person Appealed - Reversal Rate is also shown (see above explanation)
Aetna Health, Inc.	11,876	1,889	2	1 50%
Anthem Blue Cross & Blue Shield of Maine	21,589	475	322	69 21%
CIGNA HealthCare of Maine, Inc.	38,049	1,695	267	122 46%
Connecticut General Life Insurance Company	1,388	87	45	26 58%
Guardian Life Insurance Company of America	374	69	30	1 3%
Harvard Pilgrim Health Care, Inc.	494	580	16	10 63%
John Alden Life Insurance Company	221	29	13	2 15%
Maine Partners Health Plan	5,317	21	5	1 2%
MEGA Life & Health Insurance Co**	No UR	N/A	N/A	N/A N/A
Delta Dental Insurance Company (Dental Coverage Only)	No UR	N/A	N/A	N/A N/A
United Healthcare Insurance Company	No UR	N/A	N/A	N/A N/A

*Company does not break out the different types of reviews.

**Company does not sell health plans in Maine that include Utilization Review

INDEPENDENT EXTERNAL REVIEW (January 2003 - December 2003)

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 2003 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 companies listed in this chart are the only companies (of those included in this brochure) that had independent external reviews in 2003.

Insurer/HMO	Total Number of External Review Decisions in 2003	Reversed Decisions in 2003 (see definition above*)	Upheld Decisions in 2003 (see definition above*)
Aetna Health, Inc.	5	3 (one includes a partial reversal)	2
Anthem Blue Cross & Blue Shield of Maine	11	5 (one includes a partial reversal)	6
CIGNA HealthCare of Maine, Inc.	4	4 (one includes a partial reversal)	0
Maine Partners	1	0	1

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, 2003	43,095
Number of covered persons, in **self insured** health insurance plans as of December 31, 2003	10,692
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 Individuals (including sole proprietors are offered an individual HMO health plan
Accreditation designation	NCQA accreditation

Anthem Health Plans 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, 2003	67,437
Number of covered persons in **self-insured** health insurance plans as of December 31, 2003	0
Customer service phone numbers	207-822-8282 or 1-800-527-7706
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)

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, 2003	26,541
Number of covered persons in **self-insured** health insurance plans as of December 31, 2003	0
Customer service phone number (varies by type of product and possibly employer)	1-800-345-9458 or call the number on the back of the ID card
Hours the customer service phone number is staffed	8:00 am - 5:30 pm Monday - Friday
Web site	www.cigna.com
Products offered in Maine	HMO and Point of Service (POS) plans. Only HMO offered to groups with less than 50 members.
Accreditation designation	NCQA Excellent (highest accreditation rating - meets additional HEIDIS* performance standards)

Connecticut General Life Insurance Company 900 Cottage Grove Road, Hartford, CT 06152	
Number of covered persons in all **fully insured** health insurance plans issued in Maine as of December 31, 2003	9,348
Number of covered persons in **self-insured** health insurance plans as of December 31, 2003	77,070
Customer service phone number	1-800-438-0247 or call the number on the back of ID card 1-800-244-6224 (Health Information Line - 24 hrs)
Hours the customer service phone number is staffed	8:00 am - 5:00 pm Monday - Friday
Web site	www.cigna.com
Products offered in Maine	PPO, Network Point of Service (POS) to large groups
Accreditation designation	None

*HEIDIS - is an NCQA tool used by health plans to collect data about the quality of care and service they provide. HEIDIS 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

Guardian Life Insurance Company of America 7 Hanover Square, New York, NY 11211	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2003	396
Number of covered persons in **self-insured** health insurance plans as of December 31, 2003	458
Customer service phone number	1-800-873-4542
Hours the customer service phone number is staffed	7:00 am - 8:00 pm (Central Standard Time) Monday - Friday
Web site	www.glic.com
Products offered in Maine	Guardian Indemnity Insurance - Small and Large Group
Accreditation designation	NCQA for UR management and URAC

Harvard Pilgrim Health Care, Inc. 93 Worcester Street, Wellesley, MA 02481 & 48 Free Street, Portland, ME 04101	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2003	2,148
Number of covered persons in **self-insured** health insurance plans as of December 31, 2003	0
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 Excellent (highest accreditation rating - meets additional HEIDIS* performance standards)

General Company Information

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, 2003	2781
Number of covered persons in **self-insured** health insurance plans as of December 31, 2003	0
Customer service phone number	1-800-800-1212
Hours the customer service phone number is staffed	7:30 am - 6:00 pm Central Standard Time Monday - Friday
Web site	www.us.fortis.com
Products offered in Maine	Small Group, Individual Short-Term Medical
Accreditation designation	URAC

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	30,562
Number of covered persons in **self-insured** health insurance plans as of December 31, 2003	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	Small Group, and Large Group (HMO and Point of Service plans)Individual (standard and basic plans)
Accreditation designation	NCQA Excellent (highest accreditation rating - meets additional HEIDIS* performance standards)

*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.

MEGA Life & Health Insurance Company 9151 Grapevine Highway, North. Richland Hills, TX 76180	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2003	13,561
Number of covered persons in **self-insured** health insurance plans as of December 31, 2003	0
Customer service phone number	1-800-527-5504
Hours the customer service phone number is staffed	7:00 am - 7:00 pm Central Standard Time Monday - Friday
Web site	none
Products offered in Maine	Small Group Indemnity plans
Accreditation designation	N/A (no utilization review)

Patriot Mutual Insurance Company P.O. Box 1776, 14 Main Street, Brunswick, ME 04011	
Number of covered persons in all **fully insured** dental plans issued in Maine as of December 31, 2003	16,081
Number of covered persons in **self-insured** dental plans as of December 31, 2003	2,265
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 PPA Dental plans to employers with two or more eligible employees
Accreditation designation	N/A - Dental coverage only

United Healthcare Insurance Company 5105 Central Park Drive, Lincoln, Nebraska 68504	
Number of covered persons in all **fully insured** health insurance plans issued in Maine as of December 31, 2003	1,435
Number of covered persons in **self-insured** health insurance plans as of December 31, 2003	21,849
Customer service phone number	Shown on enrollee's insurance 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 Point of Service plans)
Accreditation designation	NCQA and 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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Maine Bureau of Insurance
34 State House Station
Augusta ME 04333

MAINE DEPARTMENT OF
Professional & Financial Regulation

Maine Bureau of Insurance

Guide to Requesting an Independent External Review for Health Insurance

John Elias Baldacci
Governor

Robert E. Murray, Jr.
Commissioner

Alessandro A. Iuppa
Superintendent

What is an "external review"?

Consumers may be entitled to an external review to resolve a dispute that involves medical issues with an insurance company. An external review is an additional step in the appeals process, after the insurance company denies paying your health insurance claim. The review is done by an independent company that does not have any ties to the insurance company. Typically, the external review is held after the health insurance carrier's internal appeal process has been completed (usually two appeals).

The Bureau of Insurance contracts with external review organizations (EROs) which are independent from insurance companies. If you qualify for the external review, the Bureau will assign your case to one of these organizations.

The EROs will have the appropriate health experts review your case. For example, if your case involves a mental health issue, then a psychiatrist or other suitable mental health professional, who is experienced with your diagnosis, will be assigned to review your case. The ERO also ensures that the health professional has no conflicting relationship with your insurance company.

How do I qualify for an external review?

To qualify for an external review, your insurance policy has to be in a "fully-funded" plan. In other words, it has to be a true insurance policy, and not from a "self-funded" plan that is funded by your employer (usually large employers). You can find out if your plan is a fully-funded health plan by asking your insurance carrier or the human resource department where you work.

When a health insurance claim is denied, State law requires fully-funded health insurance carriers to provide you with two levels of appeal. The process for the appeals that are conducted by the insurance company must follow rules established by the Maine Bureau of Insurance. If you are not satisfied with the decisions of the two appeals to the insurance company, you can request an external review. You must apply for the external review within 12 months after the second level appeal is denied.

Also, to qualify for external review, your complaint has to involve one of the following:

- *Medical Necessity* - health care services or products that a physician or health care practitioner would provide to a patient in order to prevent, diagnose, or treat an illness, injury or disease. Occasionally, an issue may be deemed medically necessary but is not covered in the policy. If there is clearly no coverage in your policy, then you do not qualify for the external review.

- *Pre-existing Conditions* – health conditions that you may or may not have when you start coverage under a new insurance policy.

- *Experimental or Investigational* – the treatment is determined to be scientifically unproven by insurance company standards.

- *Medical Diagnosis, Care or Treatment*

Will I be required to pay for the external review?

You will not be required to pay for the external review. The only costs to you will be for things like postage and time off from work to attend the telephone hearing, if you choose to participate.

How do I request an external review?

Call or write to the Bureau of Insurance to request an external review. A packet will be sent to you that includes a contact sheet and a permission slip. The contact sheet needs to be filled out by you if you want to participate in the telephone hearing. You can list yourself, your health care provider (you may want to ask your health care provider to participate in the hearing), and you can also request a particular representative from the insurance company to participate if you like. The ERO will use this contact sheet to schedule the hearing and will call the people at the pre-arranged day and time using the telephone numbers you supplied on the sheet. After filling out the contact sheet, sign the permission slip and mail these to the Bureau of Insurance along with a copy of the second level appeal denial letter you received from the insurance company. The Bureau will use the second level appeal denial letter to determine if your appeal qualifies for external review. If you qualify, we will assign your case to an ERO.

Your insurance carrier will send your medical records and other information that the carrier wants the ERO to consider to both the ERO and to you. At the same time, you will have an opportunity to submit additional materials that you would like the ERO to consider when reviewing your case. Any documents that you submit to the ERO will be copied and sent to your insurance carrier. This allows everyone to have the same information when the case is reviewed.

What happens during the hearing?

The hearing is conducted by telephone as the EROs are located throughout the country. The ERO will telephone you at the number you provided on the pre-arranged day and time that you agreed to. The external review organization will also call anyone else on the contact sheet that you have identified as willing to take part in the hearing. Your health-care provider's participation is not necessary, but they may help you to explain your position more clearly. If your healthcare provider cannot participate in the telephone hearing at the prearranged time, ask him or her to submit a written statement in support of your case prior to the phone call. The ERO will also contact your insurance company representatives and connect them to the conference call.

Each ERO may have its own way of conducting the hearing but generally, all participating parties will first be introduced. The ERO coordinator will ask you if you have any information you'd like to present. You will have about 15 minutes to present your information. This is your time to explain the reasons why you feel your case is justified. Use this time to get your important points across. Before the hearing, jot down the important points that you want to make so that you won't forget. If you have one of your healthcare providers take part in the conference call, he or she can offer information to help your case. Very few people who have an external review hire an attorney to represent them but if you do, they will also have an opportunity to address the issues.

Your insurance company will have the same amount of time to justify their denial of your claim. After their presentation, you will have an opportunity to ask the insurance representative questions. The ERO may also ask you or the insurance company questions. The conference will end after about 45 minutes to an hour.

When will I learn the results of the review?

The ERO is required to complete the external review within 30 days after it initially receives the case for review. They will review all the materials submitted and the information presented at the hearing. They will send you and your health insurance carrier a written decision within a week after the hearing.

The external review decision is **binding only on the health insurance carrier**. In other words, if the ERO decision is in your favor, the insurance company must comply. If the decision is not in your favor, you can take further private legal action on your own if you choose.

What is the Bureau of Insurance's role in the external review process?

The Bureau's only role is to arrange for the external review. When the ERO begins the process, the Bureau's role is ended. We cannot advise you concerning what to say at the hearing. Also, we cannot send paperwork to the ERO on your behalf.

The external review is the last step in the official appeals process monitored by the Maine Bureau of insurance.

For more information:

Call or write:

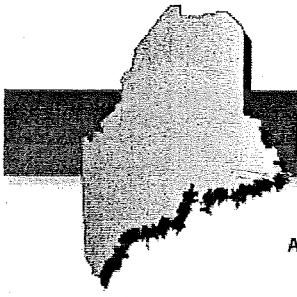
Consumer Health Care Division
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Tel. 1-800-300-5000 (in Maine) or
1-207-624-8475

Visit the Bureau's web site at: www.MaineInsuranceReg.org

November 2003

Maine Bureau of Insurance
34 State House Station
Augusta ME 04333



MAINE TAX QUALIFIED and TAX CERTIFIED 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:

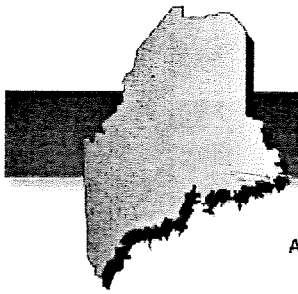
1. Premiums were deductible on individual and corporate Maine tax returns for any long term care (LTC) policy or contract the Superintendent of Insurance, through 1999, certified as eligible for the tax incentives in Title 36 M.R.S.A. §§ 5122 *et seq.* **Once certified**, the policy or contract became 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	10/5/2000
	GR-N280	10/5/2000
	GR-N410	2/12/2001
	GR-N370	6/17/2002
	GR-N380	6/17/2002
	GR-N430	9/24/2003
Golden Rule Insurance Co. **7440 Woodland Drive** **Indianapolis, IN 46278-1719**	GRI-L-70-18	6/4/2003
Great American Life Insurance Co. **Box 26580** **Austin TX 78755**	2LTCIP0001(ME)	7/26/2004
Mutual Protective Ins. Co. **Box 3477** **Omaha NE 68103**	MP-LT201(ME)	3/12/2002
Penn Treaty Life Insurance Co. **3440 Lehigh Street** **Allentown PA 18105-7006**	PF3-A(ME)	11/6/2003
	FPF3-A(ME)	11/6/2003
Valley Forge Life Insurance Co. **CNA Plaza** **Chicago IL 60685**	PO-N0202-A18	8/28/2002

Last Updated: **August 2, 2004**

FREQUENTLY ASKED QUESTIONS – HEALTH

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. For groups with 50 or fewer employees, this will change beginning July 1, 2004. The Bureau will have approval authority over small group rates unless the insurer agrees to refund premiums if claims paid turn out to be less than 78% of the premium. 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) through (2-C).

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).

Return to top

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.

Return to top

Long Term Care Insurance

When can I deduct long term care premiums on my Maine income tax return?

When your pollicy is **either** "tax qualified" or is "certified" for the deduction.

Premiums for federally tax-qualified long term care policies are automatically deductible on Maine income tax returns. This is true **irrespective of the date the policy became federally qualified**. The first page of the policy must disclose whether it is federally qualified, except for policies issued before the federal deducation was enacted into the Internal Revenue Code. These older policies are "grandfathered" as federally qualified, and as such, are among the policies automatically Maine qualified.

Premiums paid for a policy not Maine qualified *may* be entitled to the same tax incentives as a qualified plan if the Maine Superintendent of Insurance has **certified** the policy for the deduction. For more information, see: www.state.me.us/pfr/ins/ltc_tax_qualified.htm.

Is there a difference in benefits payable under tax-qualified or tax-certified versus non-qualified or non-certified 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 qualified or certified plan. For more information, see: www.state.me.us/pfr/ins/ltc_tax_qualified.htm.

WHAT SHOULD I LOOK FOR WHEN I BUY HEALTH INSURANCE?

The Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333
207-624-8475 or 1-800-300-5000 (in Maine)
http://www.MaineInsuranceReg.org

John Elias Baldacci
Governor

Robert E. Murray, Jr.
Commissioner

Alessandro A. Iuppa
Superintendent

Few decisions are as important as choosing health insurance. However, choosing the right insurance can be difficult. There are many things to consider before you make a final decision. Before buying a policy, it is very important to learn what plans offer and which plan would meet your needs.

This brochure is intended to help people to shop for health insurance policies for themselves or their families, people receiving Medicare who are looking for supplemental insurance, and people who are self-employed and eligible for small group plans. This information is a companion piece to other brochures available on our website under Consumer Information/Publications.

1. How can I tell if a company will provide me with the insurance coverage I need?

Make sure the company is licensed in the State of Maine by looking on our website under Insurance Company Information/Find a Licensee (http://www.state.me.us/pfr/ins/webquery_disclaimer_page.htm). Be careful when looking up a carrier's name to ensure that you identify it exactly. Some illegitimate plans use names that are very similar to licensed carriers. To become licensed, the company has to provide the Bureau with documentation that shows that they are financially stable.

Another good resource is a rating company. You can use www.ambest.com, www.moodys.com or www.standardpoor.com to find company financial ratings. If you don't have Internet access, call us at 1-800-300-5000 (in Maine) and ask to speak to the person who can give you an A.M. Best rating and license information.

Other information you may find helpful can be found on the Bureau of Insurance website (www.MaineInsuranceReg.org). Choose the Consumer Information link, choose the Publications heading and then select Health in the heading under Publications.. You may find the brochures listed below of particular interest.

- Health Insurers Doing Business in Maine, Consumer's Guide to - 2002
- Small Employers Health Insurance, A Consumer Guide to
- Health Insurance Complaint Ratios - 2002 (other years also listed)
- Individual Health Insurance, Guide to
- Medicare Supplement Comparison Chart

2. What about discount cards?

Discount cards are not insurance. They provide discounts for health care services or prescription drugs. You have to pay all costs beyond the discount. Some discount cards carry a monthly or yearly fee.

3. What should I consider when I choose a health policy?

What do I need? First, determine your own health needs. The questions to consider include:

- Do you or your family members have special health needs?
- Do you or your family members need to see specialists regularly?
- Do you or your family members have a condition that would be made more difficult if you couldn't see the person whom you consider to be your primary physician or specialist?
- Do you or your family members have an ongoing need for prescription drugs?

How do benefits compare? Once you know your health needs, you can compare the benefits offered by each plan. The Consumer Guide to Individual Health Insurance, the Consumer's Guide to Small Employers Health Insurance, and the Medicare Supplement Comparison Chart describe the benefits available.

Each plan may offer some benefits that meet your needs, but chances are no plan will meet them all. You have to balance what you need with what you can afford.

HMO, PPO or Indemnity? People enrolled in a Health Maintenance Organization (HMO) generally must choose a primary care physician from a list of participating doctors. For any non-emergency hospital or specialty care, enrollees must usually get a referral. A "pure" HMO plan does not provide benefits if you go to a provider who is not in the network. A point-of-service (POS) plan will pay a reduced level of benefits for services provided by non-network providers. The plan may restrict how you may access the services, how often you can use the services, and/or how much the plan will pay annually for the services.

In a Preferred Provider Organization (PPO), the health insurer contracts with a network of medical providers who agree to accept lower fees and/or to control medical costs. People enrolled receive a higher level of benefits if they go to a participating provider than if they go to a non-participating provider.

In an indemnity plan, the health insurer does not restrict your choice of provider. Benefits are usually limited to the "usual and customary" fee for the service. If your provider's fee is higher, the provider will bill you for the difference. Benefits are also usually subject to an annual deductible and coinsurance. Coinsurance is a percentage of the fee (typically 20%) that you must pay.

Can I still see my current doctor? Find out if the doctors and other health care professionals you and your family members use participate with the health plan. Determine if your providers are in the health plan's network by checking the plan's provider directories and by calling the providers' offices. If the doctor/provider is not part of the plan's network, check the difference between coverage for participating and non-participating providers. This will help you calculate what you would have to pay out-of-pocket if you really wanted to continue using that provider. Ask your providers if they have had problems with the insurance company not paying them on time or refusing to pay at all.

How's the referral system? Does the company complete referrals to another doctor/provider quickly and do they give you notice of the approved referral? Ask your doctor how quickly the company decides on referrals.

How's the customer service? Service is also important to consider. A company that gives superior service may be worth some additional cost if you can afford it. Some measures of the quality of a health insurance company's customer service are found on our website in Health Insurers Doing Business in Maine, Consumer's Guide to.

What's the bottom line? See the Individual Health Insurance, Guide to; Small Employers Health Insurance, A Consumer Guide to; or Medicare Supplement Comparison Chart publications for prices and plans listed by company. Compare benefits and premiums carefully. Consider what deductible amounts you can afford. (Most HMOs do not use deductibles; however, they may require co-payments for specific services.) See what part of your costs are paid by the plan, and whether this varies by the

type of service, doctor, or health facility used. Consider what your copayments for doctor and hospital will be, and whether you can afford the premiums of smaller copayments vs. larger copayments. Check whether there is a limit on how much the plan will pay for your care in a year or over a lifetime (keeping in mind that a single hospital stay could costs hundreds of thousands of dollars).

Can you afford it? If not, you or your family members might be eligible for MaineCare (formerly called Medicaid). To find out, call the Maine Department of Human Services at 1-877-543-7669.

4. How long do I have to keep this health insurance policy?

Generally, health care policies go from month to month, unless you have signed a longer agreement. Coverage may be cancelled if you skip a payment.

HELPFUL TIPS

■ **Don't write a check, give out your bank account number or give any person money until you are completely sure that you understand exactly what coverage you are buying**. Even if the person appears trustworthy, if you feel at all confused - wait. Give yourself as much time as you need to think about it. Ask for the business card of the individual selling you the policy. Also ask for all documents related to the policy and its benefits. Make sure you get a receipt when you do buy the policy. Read your policy and know where it is.

If you allow the insurance company to deduct payments directly from your bank account and you decide to end your insurance, it could take several months to stop the deductions and longer still to get back the money they continue to collect.

■ **Comparison shop**. Request and read copies of the insurers' brochures describing benefits and how to use them. You will find the company telephone numbers listed in the Individual Health Insurance, Guide to, Small Employers Health Insurance, A Consumer Guide to and Medicare Supplement Comparison Chart publications.

■ Take the necessary time to learn all you can about the insurance you want to buy. Ask the opinion of people who you trust and enlist their help in your search. Is your doctor familiar with this company? Get the information you need to ensure you are comfortable with your decision.

■ Don't be afraid to ask questions. **Never buy an insurance policy you do not understand.**

■ When your new insurance policy arrives, look it over carefully. Make sure you received the policy that you thought you purchased. You have a 10-day "free look" period when you may cancel the new policy if it does not meet your expectations.

■ Keep good files. Keep your insurance policy and all your insurance records in a safe place where you can easily refer to them.

■ Know your rights:

1. You have the right to understand anything the insurance company sends you. If you do not understand the information you received, call the company and ask for an explanation. Ask the company to put it in writing.

2. You have the right to disagree with your insurance company. Your policy or benefit booklet should tell you who to call when you are not happy with the company. You have the right to appeal any company decision.

3. You have the right to know who is making medical decisions about you at the insurance company. Ask the company to send you a list of names, titles, and qualifications of these people. Medical people should make medical decisions.

4. You have the right to know the reason for a denial of requested medical services. If your company denies a requested service, they must explain their decision in writing. If the company denies a requested service saying it is not medically necessary, they must explain why.

5. You have the right to seek emergency services without prior authorization in a medical emergency, but be sure to contact your insurer as soon as possible after you have gone to the emergency room.

6. You have the right to have help when you work with your insurance company. A relative, friend, doctor, or nurse may be willing to help. You always have the right to call the Bureau of Insurance for help.

■ Know your responsibilities:

1. You have the responsibility to understand your coverage and call your insurer if you have any questions.

2. You have the responsibility to get a referral from your Primary Care Provider if your plan requires referrals. Contact your insurer before you receive the referred services to make sure that they have received and approved the referral.

Other questions?

On our website, check out Frequently Asked Questions. And always feel free to call the Bureau at 1-800-300-5000.