

Health Care Appeals Section

The Health Care Appeals Section administers the 1997 legislation which created a uniform process for Arizona health insurance consumers to appeal insurer claim denials¹ or requests for services². The appeal process affords the insured an unbiased, independent, external level of review administered by the Department.

Exemptions to Arizona's Health Care Appeals Law

- Federal plans
- Workers' Compensation policies
- Self-funded employee benefit plans
- Fixed benefit plans (when benefit is based on the "health status of the insured")
- Long Term Care policies
- Medicare Supplement policies

In general, the health care appeals law³ provides a three-tiered process for insured members to contest denied claims or requests for service. Most appeals follow the standard appeals track, although the law provides an expedited track mirroring the standard process except for significantly reduced time frames

at each level. To be eligible for an expedited appeal, the insured member's treating provider must submit a written certification and supporting medical documentation indicating that the time required for the standard process "is likely to cause a significant

	<u>Standard Process</u>	<u>Expedited Process</u>
Level 1	Informal Reconsideration	Expedited Medical Review
Level 2	Formal Appeal	Expedited Appeal
Level 3	External Independent Review	Expedited External Independent Review

negative change" in the medical condition at issue in the appeal.

The insured member must exhaust the insurer's internal appeal steps (usually both levels one and two) before requesting external independent review; however, an insurer may choose to accelerate a case to external review at any of the internal levels. The last level of this process allows for a review that is external and independent of the health insurer. Once again, there are two distinct tracks that an external review can follow. If the case concerns a denial arising from a coverage or contractual issue, the Department makes the independent determination. The non-prevailing party may then appeal to the Office of Administrative Hearings, although the Department is not a participant at the hearing.

Who can request an appeal?

- The insured member
- The member's treating provider
- Parent, if a minor
- Legal guardian
- Person authorized to make decisions by a power of attorney

If the case involves a medical necessity issue, an independent medical review organization makes the final determination. The Department contracts with several independent review organizations (IROs) through the state procurement process. For each medical case, the Department selects a reviewer from its list of IROs, sends the case to the selected IRO who completes its medical review and sends its recommended decision back to the Department for final written determination. The health care insurer

¹ A denied "claim" occurs when a person has already received care, submitted a claim for payment, and the insurer refuses to pay all or any portion of the claim.

² A denial of "service" occurs when a person has requested a health care service or a referral to a specialist and the insurer refuses to pre-authorize the service. Thus, the desired service has not yet been rendered at the time of the appeal.

³ A.R.S. §§20-2530 through 20-2541.

has no direct relationship or contact with the IRO at any time during the independent review process. The Department bills the insurer for the cost of the medical review and maintains a revolving fund to pay the IRO fees on a case by case basis. This final medical determination is subject to judicial review, and cannot be appealed to the Office of Administrative Hearings.

Only appeals taken to the third level come to the Department for external review. The external review component of this mandated process provides Arizona health insurance consumers with a valuable, user friendly dispute resolution mechanism that is expeditious and inexpensive. A significant number of appeals are overturned by the insurer during the first two levels of appeal.

Health Care Appeals Statistics

Fiscal Year 2010

Total number of health care appeals subject to External Review Process: 201

- *Number of cases withdrawn as exempt from appeal process or settled by insurer: 18*
- *Number of cases decided by the Department as coverage issues: 73*
 - 70 standard appeals
 - 3 expedited appeal
 - 72 upheld in favor of the health insurer
 - 1 overturned or partially overturned in favor of the consumer
 - 8 remain pending at fiscal year end
- *Number of cases decided by an independent medical review organization: 68*
 - 73 standard appeals
 - 2 expedited appeals
 - 42 upheld in favor of the health insurer
 - 26 overturned or partially overturned in favor of the consumer
 - 7 remain pending at fiscal year end
- *Number of cases reviewed by the Department but referred to an independent medical review organization for medical decision: 45*
 - 45 standard appeals
 - 0 expedited appeal
 - 24 upheld in favor of the health insurer
 - 16 overturned or partially overturned in favor of the consumer
 - 5 remained pending at year end

Health Insurance

It is important to note that the Division regulates only about 40 percent of Coloradans' health coverage. As reported in the 2010 Annual Report on Health Care Costs³ published by the Division, approximately 55 percent of Coloradans get their health coverage through their (or a family member's) employer. Of this, 21 percent of the coverage is through employer self-funded health plans not regulated by Colorado but subject to federal law. Another six percent of Coloradans have coverage purchased in the individual insurance market.

Despite the Division's jurisdiction being limited to 40 percent of the health coverage marketplace, health insurance complaints within the Division's purview comprise about 18 to 22 percent of the complaints lodged with the Division. Of the broad category of health insurance complaints submitted to the Division in FY 10-11, 36 percent concern group insurance, and 64 percent involve health insurance in the individual marketplace. Eight complaints were about accidental death benefits, while 41 involved disability insurance benefits. Dental insurance coverage logged 19 complaints, and long-term care insurance had 69 complaints.

For health insurance, the top complaint reasons this year and over the past few years have been:

Top Ten Health Complaint Reasons

		FY 06-07	FY 07-08	FY 08-09	FY 09-10	FY 10-11
1.	Denial of Claim (CH)	21%	21%	26%	24%	25%
2.	Premium & Rating (UW)	5%	7%	6%	10%	15%
3.	Premium Notice & Billing (PS)	3%	2%	7%	10%	12%
4.	Claim Delay (CH)	18%	17%	13%	10%	9%
5.	Coverage Question (PS)	5%	5%	5%	5%	4%
6.	Misrepresentation (MS)	*	*	*	*	3%
7.	Unsatisfactory Settlement Offer (CH)	7%	5%	3%	3%	2%
	Premium Refund (PS)	4%	3%	2%	5%	2%
8.	Other (CH)	*	5%	3%	2%	2%
	Refusal to Insure (UW)	*	*	*	2%	2%
9.	Co-Pay Issues (CH)	*	*	*	*	2%
10.	Agent Handling (PS)	*	*	*	*	2%
	Percent of Total Reasons	63%	65%	65%	71%	80%

Note: Color signifies the functional area the reason falls under: Underwriting, Claims Handling, Policyholder Services, Marketing and Sales. Please note the top ten reasons are listed for each year, and an asterisk for a reason in a prior year denotes that the reason was not included in the top ten reasons in that year.

There is wide variety in types of health insurance products, i.e. Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), High Deductible Health Plans (HDHPs), etc., in the Colorado health insurance marketplace. With this variety, there is also a wide array of health conditions, services and providers covered by the various policy types outside what is mandated to be covered under state law. Section 10-16-104, Colo. Rev. Stat. contains the majority of benefits where coverage is required by Colorado health insurance plans.

³ This report can be found at <http://www.dora.state.co.us/insurance/rtfo/health%20costs/HealthCostReport.htm>.

With a substantial proportion of Coloradans getting their health coverage through a plan not regulated by Colorado – usually an employer self-funded plan – the Division refers many consumers to their employer’s Human Resources office and the U.S. Department of Labor. Federal ERISA⁴ law governs most employer self-funded plans, and the Colorado Division of Insurance does not have jurisdiction to address complaints under these types of plans. Consequently, not reflected in the statistics above is where the Division has referred a consumer with a complaint about an ERISA self-funded plan.

We note that in FY 10-11, three reasons rose to the top ten list for the first time in recent years. We note that two issues most often involving insurance producers (agents and brokers) are included in this year’s top ten reasons – Misrepresentation and Agent Handling. As consumers and businesses search to obtain the greatest value for their premium dollars, consumer education about the particulars of the insurance policy selected becomes a greater responsibility for producers.

Health Complaint Reports

Each year the Division publishes complaint ratios and indices based on health insurance carriers’ market share, premium, total complaints and confirmed complaints. The full standard and interactive reports can be found on the Division’s website at <http://www.dora.state.co.us/insurance> and clicking on “Consumer Information” and then on “Complaint Index & Reports.”

The “Complaint Ratio” shows how many complaints a company generates per \$1 million of premium. The ratio provides helpful information to consumers interested in evaluating their insurance carriers, and to State regulators in targeting companies requiring closer review. For example, a complaint ratio of 4.40 means the company had approximately 4.40 complaints per \$1 million worth of business.

The column entitled “Complaint Index” provides a calculation of the number of a specific carrier’s complaints compared to the industry average. The index is calculated by dividing a company’s share of complaints by its share of premium. An index higher than 1.0 indicates that a company’s complaint counts are higher than average, and an index lower than 1.0 indicates that a company’s complaint counts are lower (better) than average. An index of 0.0 (zero) indicates that no complaints were received for the company, which is always better than average.

A company’s complaint index is generally considered to be more informative than the complaint ratio, because it adds at-a-glance information indicating how each insurer compares to the rest of the marketplace. Consumers are cautioned against relying **only** on the Complaint Ratio and/or the Complaint Index when evaluating companies. Premiums, benefits, financial condition, and level of service should all be considered.

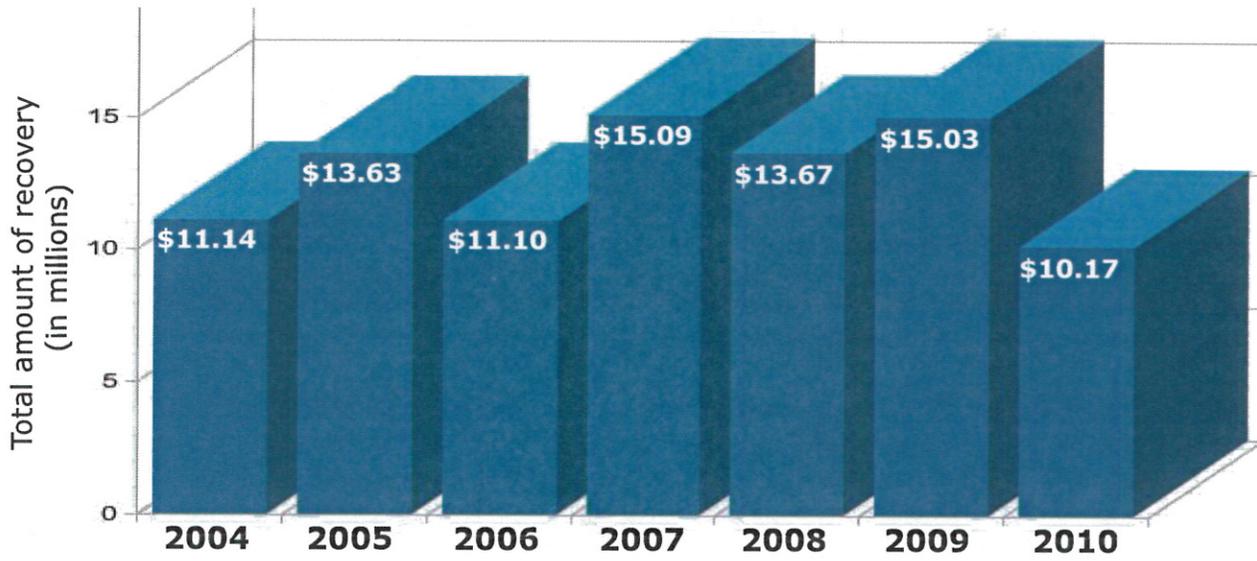
In the chart following, the complaint ratios and indices for the top twenty largest (by premium volume) health carriers in Colorado are listed. Please note that this information is calculated on a calendar year basis.

⁴ An ERISA health plan that is self-funded is one where the employer provides the funds for health care benefits and determines benefit levels. ERISA stands for the federal Employee Retirement Income Security Act which covers a wide range of employee benefits, including health coverage.

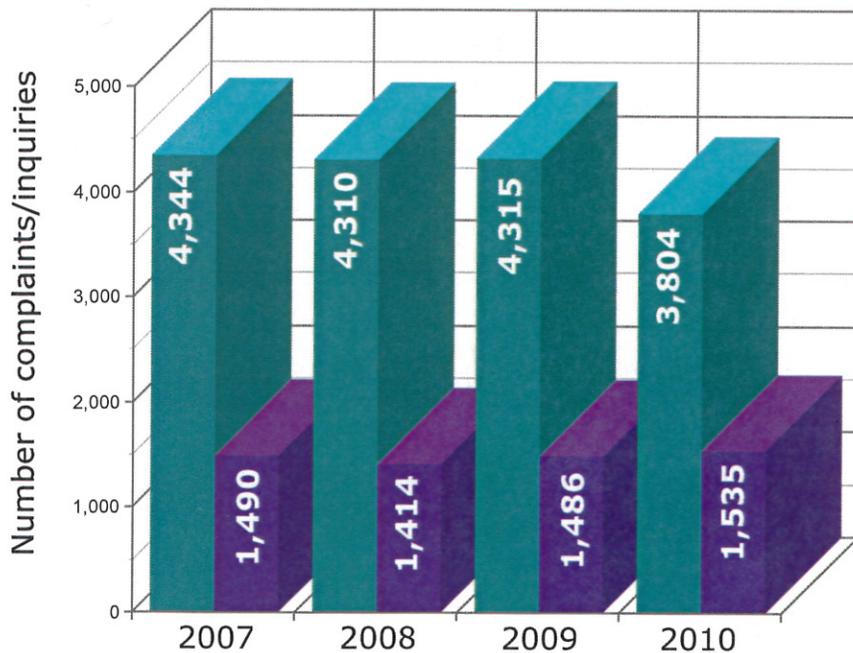
Facts and figures

Recoveries

Recoveries are the claim amounts recovered for consumers by the Kansas Insurance Department in excess of the amount initially offered by insurance companies.



Complaints and inquiries



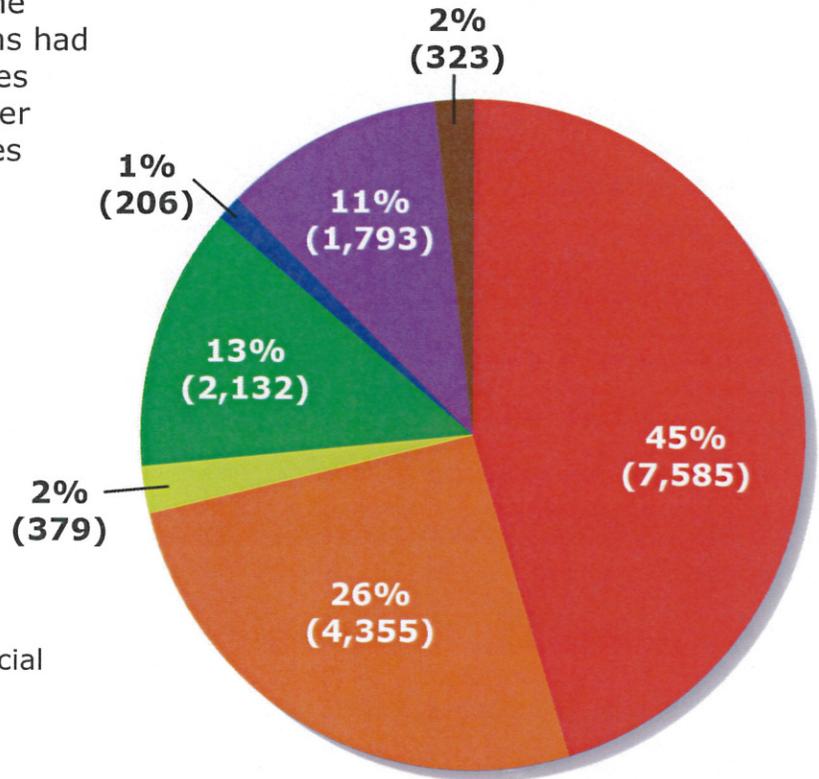
A complaint is a written grievance filed by an insurance consumer or an authorized advocate in which a Consumer Assistance representative contacts an insurance company. Inquiries are informal questions addressed to representatives. Complaint figures have continued a downward trend in recent years.



Complaints by line of insurance (closed 2007-2010)

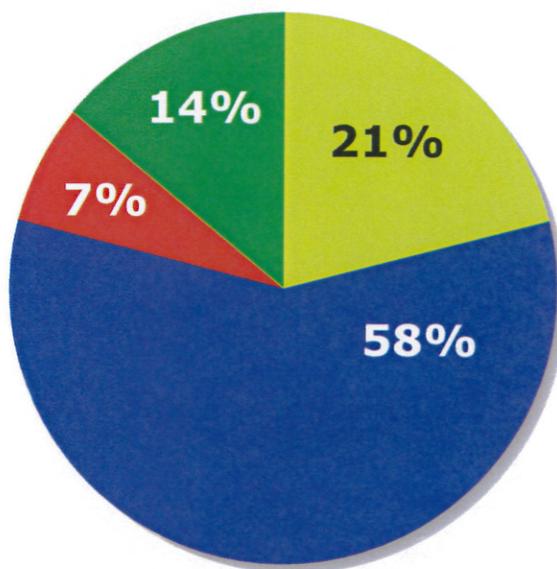
For each type of complaint, the majority concerned how claims had been handled. Other categories were underwriting, policyholder services and marketing & sales (see graph below).

- Accident & Health
- Miscellaneous
- Life and Annuity
- Liability
- Homeowner's
- Fire, allied lines and commercial multi-peril
- Auto



Consumer complaint breakdown

Consumer complaints received by the department are broken down into categories. The following categories are most often represented.



- Claim Handling
- Policyholder Service
- Underwriting
- Marketing & Sales

Texas



Insurance & HMOs

HMO Complaints for Calendar Year 2009

(January - December)

Basic Service HMOs	Total Complaints (Closed Cases)	Justified Complaints	Enrollment	Ratio of Justified Complaints per 10,000 Enrollees
AETNA HEALTH INC.	209	49	210,003	2.33
AMERIGROUP TEXAS, INC.	84	2	504,656	0.04
ARCADIAN HEALTH PLAN, INC.	51	2	28,962	0.69
BLUE CROSS AND BLUE SHIELD OF TEXAS, A DIVISION OF	182	32	7,733,536	0.04
BRAVO HEALTH TEXAS, INC.	168	13	16,155	8.05
CIGNA HEALTHCARE OF TEXAS, INC.	32	12	29,331	4.09
COMMUNITY FIRST HEALTH PLANS, INC.	6	1	112,340	0.09
COMMUNITY HEALTH CHOICE, INC.	4	1	149,857	0.07
COOK CHILDREN'S HEALTH PLAN	6	0	72,793	0.00
EL PASO FIRST HEALTH PLANS, INC.	3	1	57,532	0.17
EVERCARE OF TEXAS, L.L.C.	151	9	98,156	0.92
HUMANA HEALTH PLAN OF TEXAS, INC.	143	31	186,151	1.67
MERCY HEALTH PLANS OF MISSOURI, INC.	3	0	36,896	0.00
MOLINA HEALTHCARE OF TEXAS, INC.	12	0	39,574	0.00
PACIFICARE OF TEXAS, INC.	461	18	152,446	1.18
PARKLAND COMMUNITY HEALTH PLAN, INC., A PROGRAM OF	10	0	167,789	0.00
PHYSICIANS HEALTH CHOICE OF TEXAS, LLC	44	0	18,033	0.00
SCOTT AND WHITE HEALTH PLAN	70	28	157,255	1.78
SELECTCARE HEALTH PLANS, INC.	26	2	5,479	3.65
SELECTCARE OF TEXAS, L.L.C.	234	6	44,747	1.34
SETON HEALTH PLAN, INC.	1	1	17,201	0.58
SHA, L.L.C.	58	7	80,979	0.86
SUPERIOR HEALTHPLAN, INC.	30	11	300,893	0.37
TEXAS CHILDREN'S HEALTH PLAN, INC.	6	1	243,673	0.04
TEXAS HEALTHSPRING, LLC	68	6	49,587	1.21
UNICARE HEALTH PLANS OF TEXAS, INC.	12	3	39,640	0.76
UNITED HEALTHCARE OF TEXAS, INC.	83	8	7,278	10.99
VALLEY BAPTIST HEALTH PLAN, INC.	7	1	19,686	0.51
Average:	77	9	377,880	1.48
Single & Limited Service HMOs	Total Complaints (Closed Cases)	Justified Complaints	Enrollment	Ratio of Justified Complaints per 10,000 Enrollees
AETNA DENTAL INC.	5	0	323,044	0.00
ALPHA DENTAL PROGRAMS, INC.	14	5	72,679	0.69
CIGNA DENTAL HEALTH OF TEXAS, INC.	4	2	178,829	0.11
MANAGED DENTALGUARD, INC.	4	2	66,992	0.30
NATIONAL PACIFIC DENTAL, INC.	8	4	156,512	0.26
SAFEGUARD HEALTH PLANS, INC.	8	4	134,724	0.30
UNITED CONCORDIA DENTAL PLANS OF TEXAS, INC.	3	3	4,160	7.21
UNITED DENTAL CARE OF TEXAS, INC.	1	0	86,302	0.00
VALUEOPTIONS OF TEXAS, INC.	2	0	388,148	0.00
Average:	5	2	156,821	0.98

Count includes Record Only and CHIP

For more information contact:

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Consumer Help 1-800-252-3439
Report Fraud 1-888-327-8818

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Consumer Complaints Against Commercial Health Insurance Companies

A key function of the Insurance Department is to assist consumers with questions and concerns that they have about commercial health insurance coverage. The primary agency within the Insurance Department that assists consumers with health insurance issues is the Office of Consumer Health Assistance (OCHA).

OCHA seeks to provide a variety of needed services to health care consumers and policymakers, including (but not limited to):

- Assisting consumers in understanding their contractual rights and responsibilities, statutory protections and available remedies under their health plan
- Providing health care consumer education (producing, collecting, disseminating educational materials; conducting outreach programs and other educational activities)
- Investigating and resolving complaints
- Assistance to those having difficulty accessing their health care plan because of language, disability, age, or ethnicity
- Providing information and referral to these persons as well as help with initiating a grievance process
- Analyzing and monitoring federal and state regulations that apply to health care consumers

OCHA processes more than 5,000 consumer inquiries each year (see Table 4). These inquiries range from simple questions about how to obtain health insurance coverage to complaints against a particular health insurance company.

Table 4. Estimated Number of Consumer Inquiries Handled by OCHA Staff: 1999 - 2008

Consumer Inquiries ^a	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Telephone (in/out)	6,234	14,108	14,886	11,535	10,054	9,213	8,633	7,125	5,180	4,201
Walk-in	38	67	27	36	75	83	43	33	16	26
Other (in/out)	172	63	516	682	999	1,217	736	616	825	1,119
Total Inquires	6,444	14,238	15,429	12,253	11,128	10,513	9,412	7,774	6,021	5,346

Data Source: Utah Insurance Department

^a The Office of Consumer Health Assistance (OCHA) was created July 1, 1999. Data reported here is only for consumer inquiries received after the creation of OCHA.