

**State of Maine  
Bureau of Insurance  
Health Report Card Survey - 2017**

Carrier Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone Number, Email: \_\_\_\_\_

***This form (located at [http://www.state.me.us/pfr/ins/company\\_forms.htm](http://www.state.me.us/pfr/ins/company_forms.htm)) is due March 1, 2017. Completion fulfills the requirements of Title 24-A, MRSA §4302(2). All information requested should be provided for calendar year 2016 (January 1 through December 31, 2016). Mail or email the completed form to Violet M. Hyatt ([violet.hyatt@maine.gov](mailto:violet.hyatt@maine.gov)), Maine Bureau of Insurance, 34 State House Station, Augusta, ME 04333.***

<b>Background Information</b>	
Number of covered persons (based on Maine residency) in all fully insured health insurance or HMO plans issued as of 12/31/16.	
Number of covered persons (based on Maine residency) covered in self-insured health plans administered by the carrier as of 12/31/16.	
Customer Service phone number	
Days/hours the customer service phone number is staffed	
Website	

<b>Background Information, cont'd.</b>	
Accreditations (e.g. NCQA, URAC, etc.)	
Products offered in Maine (list by product name and indicate product type [e.g. HMO, POS, PPO] and in which market the product is available [e.g. individual, small group, large group])	
Geographic area(s) in Maine in which products are offered	
Provider-to-enrollee ratio by geographic region	
Provider-to-enrollee ratio by medical specialty	

<b>Utilization Review<sup>1</sup></b>
<p><b><i>If UR subcontractors are utilized (e.g. mental health network and claims administrators), please provide the following for <u>EACH</u> subcontractor:</i></b></p>
<p>1. Name</p>
<p>2. Address</p>
<p>3. Scope of UR review (e.g. mental/behavioral health service authorization request review)</p>
<p>4. 800 or collect call phone line for covered persons &amp; providers to access review staff contact person</p>
<p>5. Accreditation, if any (e.g. URAC)</p>

<sup>1</sup> 850(5)( RR). "Utilization review" means any program or practice by which a person, on behalf of an insurer, nonprofit service organization, 3rd-party administrator or employer, which is a payor for or which arranges for payment of medical services, seeks to review the utilization, clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Decisions regarding medical necessity made by a covered person's primary care provider do not constitute utilization review.

## Utilization Review (cont'd.)

***Please answer the following questions for either the carrier (if it conducts its own UR activities), or for EACH UR subcontractor (if utilized)***

Total number of utilization review requests	
Number of <u>initial</u> requests for service authorizations including prospective <sup>2</sup> or concurrent <sup>3</sup> service authorization requests	
Number of requests for service authorizations for <u>ongoing</u> care	
Number of utilization review requests in which the services requested or performed include chiropractic services	
Total number of <u>initial</u> adverse utilization review determinations <sup>4</sup>	
Total number of initial adverse utilization review determinations that were appealed	
Total number of initial adverse utilization review determinations that were appealed and <u>reversed</u> in favor of the covered person on appeal or at second level grievance review	
Number of lawsuits filed by enrollees over UR decisions	

<sup>2</sup> Rule 850(5)(HH). "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

<sup>3</sup> Rule 850(5)(K). "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

<sup>44</sup> Rule 850(5)(A). "Adverse determination" means a determination by a health carrier or its designee utilization review entity (URE) that: 1) an admission, availability of care, continued stay or other health care service has been reviewed and does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness; and, 2) payment for the requested service is therefore denied, reduced without further opportunity for additional service, or terminated.

<b>Complaints and Grievances<sup>5</sup></b>	
Total number of enrollee complaints and grievances	
Number of enrollee complaints/grievances related to: claim denials/delays	
Number of enrollee complaints/grievances related to: medical necessity of care	
Number of enrollee complaints/grievances related to: accessibility of care	
Number of enrollee complaints/grievances related to: behavioral health	
Number of enrollee complaints/grievances related to: chiropractic services	
Number of enrollee complaints/grievances related to: non-renewals	
Number of complaints/grievances on all other issues	
Total number of grievances that were decided in favor of the covered person at either first or second level review	
Total number, amount and disposition of malpractice claims settled by the carrier	
Describe types of actions taken, if any, to improve complaint/grievance handling and eliminate the causes of valid complaints/grievances	

<sup>5</sup> Rule 850(5)(S). "Grievance" means a written complaint submitted by or on behalf of a covered person regarding the: (1) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) Claims payment, handling or reimbursement for health care services; or (3) Matters pertaining to the contractual relationship between a covered person and a health carrier.

<b>Disenrollments</b>	
Number of enrollees <sup>6</sup> who disenrolled from the carrier voluntarily	
Five (5) most common reasons stated by these enrollees for their disenrollment	
Number of enrollees who disenrolled from the carrier involuntarily	
Number of providers who disenrolled from the carrier	
Five (5) most common reasons stated by these providers for their disenrollment	

<b>Enrollee Satisfaction</b>	
Does the carrier conduct CAHPS <sup>7</sup> surveys among enrollees (yes/no)? If yes, please provide a copy of the results.	
If no to above, how does the carrier gauge enrollee satisfaction? Please provide the results obtained through these methods.	
What actions, if any, has the carrier taken as a result of collecting and analyzing enrollee satisfaction data?	

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<sup>6</sup> "Enrollees" include dependents.

<sup>7</sup> Use of CAHPS® (Consumer Assessment of Health Plans) is **not** mandated by either Maine statutes or regulations.