State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

Prepared by:

HEALTH EDUCATION AND ADVOCACY UNIT
CONSUMER PROTECTION DIVISION
OFFICE OF THE ATTORNEY GENERAL

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I. Executive Summary

The Health Education and Advocacy Unit (the "HEAU") of the Office of the Attorney General's Consumer Protection Division submits this annual report on the implementation of the Health Insurance Carrier Appeals and Grievances Law[1] (the "Appeals and Grievances Law") as required by the Maryland Insurance Article §15-10A-08 and the Maryland Commercial Law Article §13-4A-04. Section 15-10A-08(b)(1) of the Maryland Insurance Article requires the HEAU to publish annually a summary report on the grievances and complaints filed with or referred to a carrier, the Commissioner of the Maryland Insurance Administration (the "MIA"), the HEAU, or any other federal or State government agency or unit during the previous fiscal year. Section 15-10A-08(b)(2) of the Maryland Insurance Article also requires the HEAU to evaluate the effectiveness of the internal grievance process and complaint process available to members, and to include in its annual summary report the results of this evaluation and any proposed changes that the HEAU considers necessary.

This report covers grievances and complaints filed or referred during State Fiscal Year 2022, beginning July 1, 2021, and concluding June 30, 2022.

This report (1) summarizes the Appeals and Grievances Law; (2) discusses how health insurance carriers, the MIA, and the HEAU implement the Appeals and Grievances Law; (3) summarizes grievances and complaints handled by carriers, the MIA and the HEAU; and (4) provides additional information about HEAU activities.

II. Overview of the Appeals and Grievances Process

State Law

In 1998, the General Assembly enacted the Appeals and Grievances Law to provide patients a process for appealing their health insurance carriers'[2] medical necessity "adverse decisions." All carriers must establish a grievance process that complies with the Appeals and Grievances Law. The Appeals and Grievances Law established guidelines that carriers must follow in notifying patients of denials, establishing appeals and grievances processes, and notifying members of grievance decisions.

In 2000, the General Assembly enacted Chapter 371[3] that expanded the grievances process to include the right to appeal contractual "coverage decisions." As a result, patients in Maryland who have coverage from a State-regulated plan can challenge any decision by a carrier that results in the total or partial denial of a covered health care service. In 2011, the General Assembly enacted Chapters 3 and 4,[4] which expanded the definition of "coverage decisions" to include

[1] Md. Code Ann., Insurance §15-10A-01 through §15-10A-10.

[2] The Appeals and Grievances Law defines "carrier" as (1) an authorized issuer that provides health insurance in the State, (2) nonprofit health service plan, (3) health maintenance organization, (4) dental plan, or (5) any other person that offers a health benefit plan subject to regulation by the State.

[3] Md. Code Ann., Insurance §15-10D-01 through §15-10D-04.

[4] Chapters 3 and 4 made other changes to processes and rights under the Appeals and Grievances Law that became effective July 1, 2011.

a carrier's decision that someone is ineligible for coverage or a carrier's decision that results in the rescission of an individual's coverage.

In 2022, the General Assembly enacted Chapter 229[5] to implement section 110 of the federal No Surprises Act, requiring among other things, beginning not later than January 1, 2022, the external review process to apply with respect to any adverse determination by a plan or issuer under PHS Act section 2799A–1(preventing surprise medical bills for out-of-network emergency services and services by out-of-network providers at in-network facilities) and 2799A–2 (ending surprise air ambulance bills).

As a result, patients in Maryland-regulated plans have been able to challenge any decision by a carrier that results in the total or partial denial of a covered health care service, the denial of eligibility for coverage, the rescission of coverage, or the failure to apply the cost-sharing and surprise billing protections in the No Surprises Act.

As amended, Maryland law has two similar processes for patients to dispute carrier determinations; one for carriers' denials that proposed or delivered health care services are not or were not *medically necessary* ("adverse decisions") and another for carriers' determinations that result in the *contractual exclusion* of a health care service ("coverage decisions").

Federal Law

Under the Patient Protection and Affordable Care Act (the "ACA"), consumers have the right to appeal health plans' decisions rendered after March 23, 2010. Through guidance and regulations issued in July 2010[6] and July 2011[7], the U.S. Departments of Health and Human Services ("HHS"), Labor, and Treasury standardized internal claims and appeals and external review processes for group health insurance plans and health insurance issuers offering coverage in the group and individual markets. Under the regulations, consumers have the right to:

1. information about why a claim or coverage has been denied and how they can appeal that decision;

2. appeal to the insurance company to conduct a full and fair review of its decision (*internal appeals*); and

3. take their appeals to an independent third-party review organization ("IRO") for review of the insurer's decision (*external review*) for claims that involve (a) medical judgment (including but not limited to those based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer, or (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

[5] Md. Code Ann., Insurance §15-146(b)(application of No Surprises Act)-(d)(MIA No Surprises Act enforcement authority).

[6] 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 23, 2010).

[7] 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 26, 2011).

In 2011, HHS deemed the Maryland laws dealing with internal and external review as meeting the "strict standards" included in the July 2010 rules.

In October 2021[8], HHS, Labor, Treasury, and Office of Personnel Management (OPM) issued Interim Final Rules amending the 2015 final rules in order to implement section 110 of the No Surprises Act, requiring, beginning not later than January 1, 2022, the external review process to apply with respect to any adverse determination by a plan or issuer under PHS Act section 2799A–1(preventing surprise medical bills for out-of-network emergency services and services by out-of-network providers at in-network facilities) or 2799A–2 (ending surprise air ambulance bills).

Accordingly, Maryland continues to implement the Appeals and Grievances Law as described below.

III. Phases of the Appeals and Grievances Process

For both adverse decisions and coverage decisions, the appeals and grievances process begins when a patient receives notice from the carrier that the carrier has rendered an adverse decision or coverage decision. Carriers must provide patients with a written notice that clearly states the basis of the carrier's adverse or coverage decision and that the HEAU is available to mediate the dispute with the carrier or, if necessary, help the patient file a grievance or appeal. The notice must also inform the patient that an external review of the decision is available through the MIA or other external reviewer following exhaustion of the carrier's internal process. Patients may file a complaint with the MIA or other external reviewer prior to exhausting the internal grievance process only when there is a compelling reason.

After receiving the initial denial, the patient[9] may contest the determination through the carrier's internal grievance or appeal process. After receipt of the grievance or appeal, the carrier has 30 working days to review adverse decisions involving pending care and 45 working days for already-rendered care. For coverage decisions, the carrier has 60 working days after the date the appeal was filed with the carrier to render a decision. The carrier must issue a written decision to the patient at the conclusion of this internal process.

If the carrier's final decision is unfavorable, the patient may file a complaint with the MIA or other external reviewer for an external review of the carrier's adverse decision or coverage decision involving medical judgment. Other coverage decisions of carriers regulated by the MIA can be appealed to the MIA under State law. The ACA's implementing regulations did not extend external review rights for coverage decisions based strictly on contractual language unrelated to those decisions requiring medical judgment.

[8] 5 CFR Part 890 (OPM); 29 CFR Part 54 (Treasury); 29 CFR 2590 (Labor: 45 CFR 147 (HHS)(Oct. 7, 2021).

[9] Throughout this report, we refer to the rights of patients during the appeals and grievances process. The Appeals and Grievances Law also gives health care providers and, pursuant to Chapters 3 and 4 of 2011, the patient's representative, if any, the right to file appeals and grievances on behalf of patients.

IV. Carrier Reporting

The Appeals and Grievances Law requires carriers to submit quarterly reports to the MIA on the number of adverse decisions issued and the number and outcomes of internal grievances the carriers handled. The MIA then forwards these reports to the HEAU for inclusion in this report. Although the carriers' quarterly report data provide some basic insight into the carriers' internal grievance processes, its usefulness is limited by several factors, including:

- The carriers are only required to report information on medical necessity denials (*adverse decisions*). Accordingly, the State does not collect comprehensive information about the types and outcomes of contractual exclusions of health care services (*coverage decisions*) rendered by the carriers.

- The carriers do not report data about each individual grievance. The carriers divide their data into medical service categories and report on the limited data within each category. As the categories are not standardized, reporting and categorizing may vary significantly from one carrier to another, making it difficult to compare one carrier's data set to that of another.

- The diagnosis and procedure information carriers report is incomplete. Carriers must report diagnostic or treatment codes for a limited number of complaints. Although the limited data provide basic evaluative information, complete reporting would provide a more valuable tool in analyzing grievance data.

- Carriers are not required to identify the grievances that involved the MIA or the HEAU. As this information is not present, it is impossible to check the cases reported by carriers against the data recorded by the MIA or the HEAU to verify the consistency of data reporting.

- An analysis of the number of adverse decisions and grievances compared to enrollee numbers cannot be performed because carriers are not required to report membership or enrollee numbers.

- An analysis of the number of adverse decisions and grievances compared to number of claims processed cannot be performed because carriers are not required to report claims numbers.

The HEAU recommends amending Md. Code Ann., Insurance §15-10A-06(a)(1) to require carriers to report the number of clean claims processed in relation to the number of adverse decisions issued and grievances filed for inclusion in this Annual Report.

Carrier Statistics FY 2022

In addition to the highlights below, statistical details from the data submitted by carriers appear in charts on pages 20-28 of this report.

1. Carriers reported 88,539 adverse decisions in FY 2022, 9,522 more adverse decisions than reported in FY 2021. Many carriers increased the number of adverse decisions issued in FY 2022 over FY 2021. Notably, in FY 2022, for carriers that reported more than 1,000 adverse decisions:

    - CareFirst BlueChoice, Inc. issued 9% more adverse decisions than in FY 2021;
    - CareFirst of Maryland, Inc. issued 15% more adverse decisions than in FY 2021;
    - CIGNA Health and Life Insurance Company issued 19% more adverse decisions than in FY 2021;
    - Dominion Dental Services, Inc. issued 71% more adverse decisions than in FY 2021;
    - Group Hospitalization and Medical Services, Inc. issued 23% more adverse decisions than in FY 2021;
    - Guardian Life Insurance Company of America issued 63% more adverse decisions than in FY 2021;
    - Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. issued 42% more adverse decisions than in FY 2021;
    - Optimum Choice, Inc. issued 14% more adverse decisions than in FY 2021; and
    - UnitedHealthcare of the Mid-Atlantic issued 217% more adverse decisions than in FY 2021.

2. In FY 2022, the carriers administratively reversed only 150 of the reported adverse decisions, less than 1%.

3. In FY 2022, consumers filed 9,525 grievances, challenging less than 11% of the adverse decisions.

4. Like FY 2021, the largest percentage of grievances filed were in the pharmacy (43%), dental (32%), lab/radiology (12%), and physician (5%) service categories.

5. Overall, in FY 2022, during the internal grievance process, carriers overturned or modified 54% of their original adverse decisions.

6. Adverse decisions involving mental health/substance abuse services continue to be overturned or modified infrequently. In FY 2022, carriers reported an overturned or modified rate of 35% for mental health and substance abuse services. This rate was higher than the 23% overturned or modified rate in FY 2021.

7. In FY 2022, 50% or more of the pharmacy (65%), inpatient hospitalization (54%), and laboratory/radiology (50%) decisions were overturned.

8. In FY 2022, dental decisions were overturned 46% of the time.

9. Adverse decisions involving pharmacy claims are the most likely to be overturned as reflected in a five-year review of data: 65% in FY 2022, 69% in FY 2021, 63% in FY 2020, 59% in FY 2019, 60% in FY 2018, and 65% in FY 2017.

V. Maryland Insurance Administration (MIA)

The MIA has regulatory oversight of insurance products offered in Maryland. In 1998, the Appeals and Grievances Law was enacted by the General Assembly to provide a fair process for resolving disputes regarding the medical necessity of a proposed or delivered health care service. (See Title 15, Subtitle 10A of the Insurance Article.) Until July 1, 2011, the Appeals and Grievances law applied only to individuals with insured health benefits. However, because of the ACA expansion of external appeal rights, effective July 1, 2011, the Department of Budget and Management for the State of Maryland, and effective June 28, 2013, Cecil County Public Schools elected to use the Maryland Insurance Administration's external review process to provide external review for their self-funded employee health benefit plans.[10]

When the MIA receives a written complaint from a member, a member's authorized representative, a health care provider or facility, the MIA will review it to determine if the complaint raises issues subject to the Appeals and Grievances Law. If the Appeals and Grievances Law applies, the MIA confirms that the insurance carrier's internal grievance process has been fully exhausted because the law requires that process to be fully exhausted prior to the MIA's involvement in the matter, unless there is a compelling reason for the MIA to act prior to the exhaustion process. If the carrier's internal process has been exhausted or if there is a compelling reason to bypass the internal grievance process, within five working days of receipt of the complaint, the MIA will contact the carrier in writing requesting a written response to the complaint. Unless an extension request from the carrier is granted by the MIA, the carrier shall respond to the MIA within seven working days of receipt of the complaint (with the exception of a complaint that involves an emergency issue that must be resolved within 24 hours of receipt of the complaint), and the carrier must respond to the MIA by providing medical and claims information (including the health benefit contract) pertinent to the complaint and either uphold, reverse, or modify its denial. When the MIA does not have jurisdiction over the complaint or the carrier's internal grievance process has not been exhausted, the MIA refers the complainant to the HEAU so that the member, the member's authorized representative, a health care provider or facility can be assisted through the carrier's internal grievance process or external review process as applicable.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then the MIA will prepare the case for review. As part of the preparation, the MIA will contact the complainant and the carrier in writing, giving them a deadline for submitting additional documentation to be considered in the review as applicable. Once the MIA receives the proper documentation, the case is copied and forwarded to an Independent Review Organization ("IRO") for medical necessity review. In selecting an IRO, the MIA ensures that the IRO has an appropriate board-certified physician available to review the case. Upon receipt of the case from the MIA, the IRO then transmits the case to its expert reviewer who researches and reviews the case, renders an opinion, and transmits the opinion back to the IRO. The IRO, in turn, conducts

[10] While the MIA only conducts the external review for people with insured health benefits and the Department of Budget and Management for the State of Maryland and Cecil County Public Schools, with the exception of grandfathered plans, the ACA mandates external review processes for all group health insurance plans and health insurance issuers offering coverage in the group and individual markets. Grandfathered plans are subject to the external review process of adverse benefit determinations for claims subject to the cost-sharing and surprise billing protections of the No Surprises Act.

a quality review of the expert reviewer's opinion. For medical necessity reviews, the MIA asks the IRO to respond to specific questions as set forth in a cover letter attached to the complaint. The IRO will orally inform the MIA of the expert reviewer's determination and follow up with the written determination via facsimile, first-class mail, or electronic mail. If the IRO reviewer's recommendation is to overturn, uphold, or modify the carrier's denial, the MIA may accept this recommendation and base its final closing letter on the professional judgment of the IRO reviewer. The complainant may be notified in writing of the outcome by electronic mail, U.S. mail, or via facsimile. The MIA also forwards a copy of the IRO's medical opinion and invoice to the carrier via facsimile and U.S. mail. In all instances, the carrier that is the subject of the complaint must pay the expenses of the IRO selected by the MIA. Hearing rights to contest the MIA decision are given to all consumers, except for individuals covered under the State of Maryland employee/retiree plan. Carriers do not have a right to an administrative hearing but may file a petition for judicial review.

Maryland law requires that the MIA make a final decision on complaints within 45 calendar days of receipt of the written complaint. However, the MIA can extend cases for an additional 30 working days if information requested by the MIA has not been received. For emergency or compelling cases, the MIA will conduct an expedited external review, completing the above process within 24 hours of receipt of the complaint. A hotline number (800-492-6116) is available 24 hours a day, seven days a week to respond to these emergency or compelling cases.

MIA Statistics FY 2022

MIA-provided data are reported on the charts and tables contained on pages 29-35 of this report. The data reflect only those cases where a disposition has been rendered; pending cases are not reported.

In addition to the data reflected in the charts and tables, the MIA-reported data reveal:

1. The MIA's Appeals and Grievances Unit received 783 complaints in FY 2022. After reviewing these complaints, the MIA determined that 360 involved MIA-regulated adverse decisions.

2. The MIA referred 37 of those complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 323 complaints in which complainants challenged the carrier's grievance decision. The MIA modified or reversed the carrier's grievance decision, or the carrier reversed its own grievance decision during the MIA's investigation in 234 cases (72%). The MIA upheld 89 (28%) of the carrier decisions.

4. Like FY 2021, the largest percentages of grievances filed were in the pharmacy services/formulary issues (50%); lab, imaging, and test services (17%); physician services (12%); and dental care (9%), categories.

VI. Health Education and Advocacy Unit

The Maryland General Assembly established the Health Education and Advocacy Unit (HEAU) in 1986. The HEAU was designed to assist health care consumers in understanding health care bills and third-party coverage, to identify improper billing or coverage determinations, to report billing or coverage problems to appropriate agencies, including the Consumer Protection Division's Enforcement Unit, and to assist patients with health equipment warranty issues. Based upon the HEAU's successful efforts in these areas, the General Assembly selected the HEAU to be the State's first-line consumer assistance agency when it passed the Maryland Appeals and Grievances Law. Since then, other states have used the HEAU as a model when creating their own consumer assistance programs and the HEAU has been cited as a model in Congressional testimony in support of early federal efforts to promote programs that would assist health care consumers, including the Health Care Consumers Assistance Fund Act of 2001. Following passage of the ACA and the implementation of Maryland's Health Benefit Exchange, the HEAU began helping consumers resolve problems enrolling on the Exchange and with obtaining premium tax credits and cost-sharing reductions.

The Appeals and Grievances Law requires carriers to notify patients that the HEAU is available to assist them in mediating and filing a grievance or appeal of an adverse decision or coverage decision. The notice must also include the HEAU's address, telephone number ((410) 528-1840), facsimile number ((410) 576-6571) and email address (heau@oag.state.md.us). The HEAU conducts outreach programs to increase awareness of consumer rights under the Appeals and Grievances Law and the assistance the HEAU can provide consumers.

When the HEAU receives a request for assistance, the HEAU gathers basic information from the carriers related to the services or care denied. Specifically, the HEAU asks the carrier to provide a copy of the insurance contract provisions and the utilization review criteria upon which the carrier based the denial and to identify precisely which provisions or criteria the patient failed to meet. Carriers must provide requested information to the HEAU within seven working days from the date the carrier received the request. The HEAU also gathers information about the patient's condition from the patient and their provider to determine if the patient meets the criteria established by the health plan and assesses whether the denial is incorrect. The HEAU presents this information to the carrier for reconsideration of the denial. Many complaints are resolved during this information exchange process. If not resolved, the HEAU will prepare and file a formal written grievance or appeal with the carrier on behalf of the patient.

If, at the conclusion of the internal appeals and grievances process, the carrier continues to deny coverage for the care, the HEAU prepares an external appeal of the carrier's decision. The HEAU forwards the case to the MIA or other external entity with a copy of all relevant medical and insurance documentation, and the HEAU monitors the outcome of the external review.

A. HEAU Statistics FY 2022

The HEAU Appeals and Grievances data[11] are reported in the charts and tables contained on pages 36-52 of this report. The data reflect medical necessity, contractual, and eligibility denials. Because newly filed cases contain incomplete data, this report includes only those cases the HEAU closed during FY 2022.

The HEAU closed 1,695 cases in FY 2022.

1. 42% of the complaints closed by the HEAU involved "carriers" defined in this report to include insurers, nonprofit health service plans, HMOs, dental plan organizations, third-party administrators, utilization review agents, pharmaceutical benefit management companies, and any other entity that provides health benefit plans or adjudicates claims.

2. 12% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection-related issues.

3. 592 of the complaints closed by the HEAU were cases involving appeals and grievances. Not all the 592 appeals and grievances complaints filed with the HEAU were mediated. Some consumers, or other persons acting on their behalf, file complaints but never complete an authorization to release medical records form or an authorized representative form (for Maryland Health Connection cases), which the HEAU requires to mediate the case. Other complaints are filed for the record only or are referred to a more appropriate agency. Of the 592 appeals and grievances cases the HEAU closed during FY 2022, 436 (74%) involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 436 cases involved more than one carrier.

4. Of the 436 appeals and grievances cases the HEAU mediated during FY 2022, 26% were adverse decision (*medical necessity*) cases, 56% were coverage decision (*contractual exclusion*) cases, and 18% were eligibility cases.

5. The HEAU mediation process resulted in 65% of the medical necessity cases, 56% of the coverage decision cases, and 74% of the eligibility denial cases being overturned or modified.

6. HEAU mediation efforts resulted in a decision change in 67% of the cases involving at least one MIA-regulated plan. In cases involving non-regulated plans, the HEAU's efforts resulted in a decision change 58% of the time.

7. In FY 2022, the HEAU assisted patients in recovering or saving over $2.4 million dollars, including over $1.7 million in appeals and grievances cases.

[11] Detailed data related to the outcomes of cases handled by the HEAU unrelated to the Appeals and Grievances Law are not contained in this report; some general complaint numbers and categories are reported for informational purposes.

B. Appeals and Grievances Successes

Maryland's Appeals and Grievances Law and the assistance provided by the HEAU continue to provide significant benefits to consumers. As the report indicates, 62% of carrier denials are overturned or modified when challenged by the HEAU. While this number reflects positive results for consumers who reach out to the HEAU, it suggests that carriers are inappropriately denying claims, causing significant financial and emotional burdens for consumers.

Several examples of the HEAU's day-to-day case work highlight the importance of the consumer assistance provided by the HEAU.

1. A 42-year-old woman diagnosed with psoriatic arthritis had been stable on Remicade infusions every 6 weeks with a dosage of 7 mg/kg since 2017. In July 2021, the carrier abruptly denied the Remicade claim, declaring "you will be held to FDA dosing guidelines not to exceed [6 mg/kg every 8 weeks]." In her internal appeal letter, the rheumatologist said "I have been made aware that the new policy at [the carrier] is to automatically deny any medication for a patient that is a higher dose or more frequent schedule than what the FDA product insert guide lists; even if it is a proven dose and schedule that has had significant benefit for a particular patient. This policy will jeopardize my patient's treatments and cause disease relapse, unnecessary pain, loss of income from not being able to work and irreversible damage to her joints." With the HEAU's intervention, the denial was overturned, and the prior dosage and frequency resumed. Several other patients filed complaints about the same carrier, which was denying medication claims notwithstanding each patient's established need for medically necessary treatments tailored to their disease progression and symptoms. The HEAU also obtained reversals of those denials.

2. A 42-year-old patient and her surgeon wanted to use a transoral approach to thyroidectomy, in which the thyroid is removed via the mouth to avoid the scarring of the neck that otherwise results from a traditional approach. The patient suffered from multinodal thyroid disease and enlarged goiter. The carrier denied the pre-authorization request ($19,641). The day before the surgery, the HEAU received the patient complaint referral from the Maryland Insurance Administration because the MIA lacked jurisdiction over the self-funded plan. The HEAU immediately filed an expedited appeal. The transoral thyroidectomy was then authorized in time for the surgery to proceed on schedule.

3. A 51-year-old patient sought pre-authorization for a four-level (C3-C7) anterior cervical diskectomy and fusion spinal surgery to treat severe pain and numbness, which the carrier denied as not medically necessary. In consultation with her orthopedic surgeon, the patient elected to proceed with the surgery despite the denied pre-authorization. After the insurance claim for the surgery was denied, the internal appeals were exhausted, the result of which was an upheld denial. There was a disagreement as to whether it was the State of Illinois or the State of Maryland that had jurisdiction for the external appeal, and after that disagreement was settled with prodding from the

HEAU, it was agreed that jurisdiction for external appeal resided with the State of Maryland. An external appeal was filed with the Maryland Insurance Administration and the denial was overturned. The carrier reimbursed $56,870.58.

4. The spouse of a 64-year-old woman who died in an emergency room after being rushed to the hospital experienced hospital billing and claims processing errors in the aftermath of her death. The carrier promptly paid claims for services rendered on her date of death by the ambulance, emergency room physician, and the hospital's emergency room. But the carrier later rescinded payment of the hospital's emergency room claim ($780.94), asserting that the patient's coverage expired the day before her death. The carrier did not correct the obvious error when the spouse challenged the illogical and inconsistent claims processing. The HEAU appealed and the hospital's emergency room bill was paid several months later. In the meantime, with the coverage issue in dispute, the hospital filed a claim against the deceased patient's estate. It took persistent requests from the HEAU over several months to verify the claim against the estate had been withdrawn. Said the surviving spouse: "This fiasco (and [the carrier's] refusal or inability to expend the necessary effort to resolve it) is despicable, unethical, and inexcusable."

5. A 56-year-old patient paid $6,600 out-of-pocket for out-of-network mental health services over an 8-month period because her carrier erroneously and repeatedly denied coverage for her claims despite her plan's out-of-network coverage provisions. She filed a complaint with the HEAU, and as part of her ongoing internal appeals, we requested an "audit" of all the claims as well as her multiple phone calls and emails requesting explanations for and overturning of the denials. The claims were approved after the "audit" request, and she was reimbursed. In its letter overturning the denials, the carrier admitted "we processed the member's claims incorrectly … because we did not remove the previous adjuster notes when we updated [the patient's] records. The previous notes prevented our system from reading the new adjuster notes … . We have given feedback to the claims team in an effort to avoid similar issues in the future."

6. A 52-year-old man was receiving phototherapy and photochemotherapy (laser treatment) for severe vitiligo. Initially the carrier approved treatment for the period of January through October 2021. At the end of this period the provider requested additional sessions. The carrier denied the request for additional sessions and retroactively audited the previous claims. The carrier then began to deny services previously approved. The carrier cited a previous request for clinical documentation that was never received. The provider filed a complaint and the HEAU appealed. The original disputed claims (1/4 – 10/28, 2021) and the request for additional sessions were approved except for one outstanding request for clinical records for one session. The provider contacted the HEAU later to confirm that the final claim included with the appeal was approved, for a total value of $18,000.

7. A 69-year-old woman had dentures made by an in-network provider. The carrier approved the treatment and related services, then processed the claim accordingly. The

patient began to experience problems with the ill-fitting dentures, making them unusable. She petitioned the carrier, contesting the quality of care, to rescind the payment to allow her to start again and obtain new dentures and services from another provider. The carrier allowed an independent evaluation, but the patient could not meet the short deadline to obtain it. The carrier denied the patient's claim for coverage of replacement services and the HEAU appealed. The carrier accepted a "late" independent evaluation and ultimately agreed to: (1) void the original claim, (2) reinstate the member's benefit, (3) reimburse the member all patient cost-share ($873), and (4) identify and confirm to the provider that the patient was absolved of any further financial obligation.

8. A 31-year-old woman was referred to an oral surgeon for diagnostic evaluation of a cyst in her jaw. The oral surgeon referred the patient for a CT scan. Upon receipt of the scan, the oral surgeon performed a biopsy, and the tissue was sent to pathology. The provider submitted the claim to the patient's medical insurance carrier, but the carrier denied the claim ($5,000) for myriad reasons including contending dental codes were used rather than medical codes. The patient was stuck in the middle of conflicting contentions by the provider's billing staff and the carrier until she filed a complaint with the HEAU. We mediated the coding/coverage conflicts resulting in full payment of the claims.

While the HEAU's assistance is indisputably valuable to the patients who obtain it, mediation is a back-end solution to problems warranting front-end solutions, i.e., preventing harm caused by carriers' denials. Increased scrutiny regarding who (personnel or artificial intelligence) makes decisions and the basis for those decisions may be warranted, especially when the denial presents inherent health or safety risks to a patient.

C. Additional HEAU Activities and Data

The HEAU also assists consumers with medical billing, equipment, and records disputes; problems enrolling on the Exchange and with obtaining premium tax credits and cost-sharing reductions; and with obtaining financial assistance from hospitals.

In FY 2022, the greatest percentage of non-appeals related cases were in the following categories.

- Quality of Care - Consumer Displeased with Quality of Care
- Consumer Requesting Information or Response to Question
- Billing - Patient Feels that Charges are Too High
- COVID-19 Testing (could be appeal related)
- Billing - Failure to Refund Overpayment
- Billing - Billed for Services Not Performed
- Billing - Consumer Seeks Itemized Bill or Clarification of Charges
- Billing - Billed for Charges Already Paid
- Failure to Terminate Plan

The HEAU continues to monitor and offer consumer-centric input to State agencies involved in health policy decision making. The HEAU's director or deputy director served as a consumer representative, either as a member or in an *ex officio* capacity, on the Maryland Health Benefit Exchange's Standing Advisory Committee and Maryland Easy Enrollment Workgroup; the Maryland Health Care Commission's Health Information Exchange Advisory and Acute Care Hospital Services Workgroups; the Maryland Insurance Administration's Consumer Health Access Program for Mental Health and Addiction Care, Mental Health Parity, and Network Adequacy Workgroups; and the Health Services Cost Review Commission's Hospital Payment Plan Guidelines Workgroup.

The HEAU also provided consultative and litigation support to the Office in its efforts to advance and defend the consumer protections afforded to Marylanders by the Affordable Care Act. In addition to the Office's litigation efforts detailed in the Maryland Defense Act Report, the Office joined amicus briefs and commented on federal and State regulations supporting efforts to enhance consumer protections in the health care marketplace.

D. Areas of Concern

1. HEAU's Increased Scope of Work and Loss of Case Workers

As reported in the Executive Summary, the HEAU has long provided services to consumers in the health care marketplace, and the types of services provided has expanded significantly in the past ten years. Since passage of the ACA and the implementation of Maryland's Health Benefit Exchange (the Exchange), the HEAU has been assisting consumers with problems enrolling in qualified health plans (QHP) on the Exchange and with problems obtaining premium tax credits and cost-sharing reductions. The HEAU also assists consumers when their QHPs terminate their coverage. More recently, the HEAU has been tasked by the General Assembly to assist consumers with facility fee disputes (Md. Code Ann., Health Gen. § 19-349.2) and hospital financial assistance and billing/collection disputes (Md. Code Ann., Health Gen. § 19-214.1 and 214.3). The HEAU is also beginning to assist consumers with complaints related to the No Surprises Act and anticipates more consumers will be seeking assistance with expanded access rights to out-of-network mental health/substance use disorder providers at in-network cost.

The HEAU has effectively assisted consumers since its inception with a comparatively small staff and modest $1 million dollar budget ($613,228 is funded by the Maryland Insurance Administration (MIA) through the Health Care Regulatory Fund, and $388,444 is funded by the Consumer Protection Division). The HEAU currently has 8½ positions (2 are contractual), comprising a Director and Deputy Director, who are also Assistant Attorneys General; four full-time and one part-time Ombudsmen who staff HEAU's hotline, assist consumers with health insurance appeals and grievances, mediate consumer complaints, and train and supervise volunteers who mediate consumer complaints; a case manager; and one administrative assistant. Despite loss of funding from the Exchange in FY 2021, one of the five ombudsmen assists consumers who have problems enrolling in QHPs on the Exchange and with obtaining premium tax credits and cost-sharing reductions.

Notably, comparable programs in Connecticut and Vermont have more staff and larger budgets to serve smaller populations. Maryland's 2020 census was 6,165,129. With a 2020 census of 3.65 million, the Connecticut Office has 18 staff members and a $2.84 million dollar budget.

With a 2020 census of 645,570, the Vermont Office has 14 staff members and a $1.4 million dollar budget.

Before the pandemic, the HEAU had approximately 12 part-time volunteers and 15 part-time interns who staffed our hotline in addition to mediating consumer complaints. Throughout the pandemic the HEAU has had virtually no volunteers (one part-time volunteer returned to the office several months into calendar year 2022) and limited numbers of remote student interns each semester, increasing the caseloads and hotline hours for each Ombudsman, backed up by the Director and Deputy Director.

In fiscal year 2022, even without volunteers and strong intern numbers due to the pandemic, the HEAU handled more than 2,000 emails, fielded over 5,000 hotline calls, and closed nearly 1,700 complaints. While the HEAU continues to obtain successful resolutions for consumers, the HEAU has a four-month backlog[12] of consumer complaints because of staffing levels, less responsive providers, and the increased complexity of the cases presented. The four-month wait to assign a case for mediation understandably angers and harms consumers. However, the current resources simply do not permit the HEAU to handle the complaints as quickly as the HEAU, or the consumers, would like.

2. Maryland's Appeals and Grievance Laws Should Apply to the State Employee Health Plan

As reported in the Executive Summary, § 2719 of the ACA requires group health plans, like the State Employee Health Plan ("the Plan"), to establish an internal claims and appeals procedure that complies with the provisions of the ACA, as well as an external review of the plans' internal claims and appeals decisions. The Plan's Kaiser Permanente option is fully insured.[13] The Plan's self-insured options are administered by CareFirst and United HealthCare.

The ACA's implementing regulations establish the requirements for the internal claims and appeals process and the external review process for self-funded non-Federal governmental group health plans such as the Plan. Where such a plan is not subject to an applicable State external review process, but the State has chosen to expand access to its process, the plan may choose to comply with either the applicable State external review process that meets the minimum requirements set forth in federal law, or one of two Federal external review processes. 45 CFR § 147.136(c)(1)(ii).

Effective July 1, 2011, the Department of Budget and Management ("DBM"), elected to participate in the State's external review process to provide external review for the Plan's self-funded options, and entered into a Memorandum of Understanding with the MIA. The relevant portions of the 2011 MOU remain unchanged and in effect:

[12] Cases with statutory deadlines, like appeals and grievances cases, No Surprises Act Good Faith Estimate cases, and hospital financial assistance act cases are assigned immediately.

[13] Because the Plan's Kaiser Permanente option is fully insured, the full scope of Maryland's appeals and grievances processes set forth in Subtitles 10, 10A, 10B, 10C, and 10D of Title 15 of the Insurance Article apply.

> "[I]n order to comply with the Affordable Care Act, DBM, as administrator for the [Plan], has opted to voluntarily comply with the state external review process established in Md. Insurance Code Ann. § 15-10A-01, *et seq.*" … "DBM authorizes [MIA] to administer, on behalf of DBM as the administrator of the [Plan], the federally mandated external review process for adverse benefit determinations that are: (1) based on the medical necessity, which includes whether a health care service is experimental or investigational, or cosmetic; (2) determinations that involve medical appropriateness, health care setting, level of care, or effectiveness of a covered benefit; and (3) complaints that fall under § 15- 10A-02(d) of the Insurance Article."

Until recently, and consistent with Md. Code Ann., Insurance § 15-10A-02, Plan members were told in their contracts and adverse or grievance decision documents that they or their authorized representatives have a right to file a complaint directly with the MIA seeking external review. Once the MIA received a complaint, the MIA would notify DBM's plan administrator, requesting information needed to process the complaint in accordance with the external review process, and would seek advice from an independent review organization or medical expert as required in cases (1) based on the medical necessity, which includes whether a health care service is experimental or investigational, or cosmetic; (2) determinations that involve medical appropriateness, health care setting, level of care, or effectiveness of a covered benefit; and (3) complaints that fall under § 15- 10A-02(d) of the Insurance Article.

More recently, DBM has directed the MIA to seek DBM's approval before sending complaints to an independent review organization or medical expert, citing as its authority one of the federal external appeal processes that DBM did not elect to use pursuant to the ACA's implementing regulations. 45 CFR § 147.136(c)(1)(ii).

DBM has been denying approval for the MIA to refer the Plan's denied claims to an independent review organization or medical expert for external review. For example, DBM refused to allow referral of:

a. Denied coverage of a breast cancer index test ordered by the Plan member's oncologist, deeming the test "not medically necessary."

b. Denied coverage of a PET scan following an abnormal MRI, deeming the scan "experimental or investigational in nature."

c. Denied coverage for several Plan members with painful hypertrophic scarring on their necks and chest following a thyroidectomy procedure, deeming the pulse laser treatment to alleviate the pain to be "cosmetic" and "not medically necessary," and refusing to allow the referral because the provider is a participating provider so the members should not be responsible for the charges.

Most recently, Plan members are being directed by CareFirst to seek "external review" through DBM and not the MIA.

These changes have caused a great deal of confusion for Plan members, the MIA, and the HEAU, and have led to the inconsistent processing of claims for Plan members and the loss of external appeal rights. Plan members are understandably frustrated when they file external review complaints with the MIA, only to be later told that the MIA has no authority over the Plan. They end up distraught when DBM upholds its internal denials without providing Plan members the process they believe they are due.

The General Assembly, long before the ACA, recognized that there was widespread evidence of inappropriate denials of services and payment for medically necessary care, and created laws to ensure consumers were receiving the benefits for which they paid. Such denials often delay or prevent consumers from getting the care they need. As the MIA-reported data reflected in this report reveals, consumers who avail themselves of their external appeal rights through the State's external appeal process are awarded coverage 72% of the time. (72% of grievances investigated in FY 2022 were overturned or modified).

The HEAU believes Plan members should be entitled to the benefits of Maryland's Appeals and Grievances Law and that the law should be amended to include the Plan. Amending the law would make clear that Maryland has elected to provide Plan members the State's consumer protections and that Plan members are not subject to a federal scheme that could afford less protection. The General Assembly is permitted to regulate the Plan and there are some provisions of the Insurance Article that already apply to the Plan. *See, e.g.*, § 15-1601(d) of the Insurance Article (definition of carrier relating to the regulation of PBMs); § 2-503(a)(2)(ii) of the Personnel and Pension Article (requiring Plan to comply with §§ 15-826, 15-826.1, 15-826.2, and, as applicable to contraceptive drugs and devices, 15-831(a) through (d) of the Insurance Article).

Adding the Plan to the scope of Maryland's Appeals and Grievances Law would also give Plan members another protection not currently afforded to them – external appeal rights for stand-alone dental plans. The Maryland General Assembly has long required Maryland-regulated dental plans to provide external appeal rights to Marylanders. In FY 2022, 16% of the HEAU's appeals and grievances complaints involved dental services; 63% of the denials challenged for consumers were overturned or modified on appeal (internal and external appeals). The MIA's FY 2022 data reflects denials of dental care services being overturned or modified 67% of the time on external appeal.

Plan members do not have the benefit of having potentially erroneous dental denials overturned because Maryland law does not require the Plan to provide an external appeal For example, Plan members filed these complaints with the HEAU:

a. A Plan member had periodontal scaling and root planing in four quadrants because of evidence of bone loss, but United Concordia denied coverage of the service finding it was not medically necessary. The Plan member sought an external appeal with the MIA through his provider. The MIA advised the consumer that it had no jurisdiction over the dental plan. The Plan refused to provide an external appeal.

b. A Plan member had tooth #3 restored with a buildup and crown to replace her old three-surface amalgam filling because there was recurrent decay on the occlusal and entire lingual surface and subgingival caries on the medial surface. Her provider recommended a crown buildup and crown because the tooth had only minimal sound

tooth structure. United Concordia denied coverage of the service, finding it was not medically necessary. The Plan member sought an external appeal with the MIA through her provider. DBM refused to allow the MIA to refer to an IRO stating that although some participating providers have patients sign agreements that allow billing for denied claims, because in this case the patient would not be financially responsible for the denied claim, it would not act on the appeal request. Later, the patient was billed for the service, paid the bill, and submitted proof of payment to United Concordia. Ultimately, through the HEAU's intervention, United Concordia refunded the patient's payment and presumably recouped it from the provider. In any event, there was no independent review of the denial in the first instance.

Plan members, like other Maryland consumers, should be afforded independent external appeals when the Plan denies coverage to ensure that they are receiving the coverage for which they are paying.

3. Hospital Financial Assistance Policies

a. Calls not answered and lack of contact information

Recently enacted hospital financial assistance and debt collection consumer protections require hospitals to advise consumers that the HEAU is available to assist them when experiencing medical debt or with financial assistance application reconsideration requests. In addition to assisting consumers with their financial assistance applications, the HEAU hears from many consumers about their inability to reach hospital staff trained to work with the consumer in understanding their bills and financial assistance rights. During FY 2022, the HEAU fielded many calls from patients of one hospital system complaining about the inability to reach anyone at the phone number provided by the hospital for billing and financial assistance questions. Consumers who called the number were placed in an endless loop of pressing numbers to reach an agent, but were never able to reach one. The HEAU attempted to reach the same number over several days and experienced the same looping problem. The HEAU contacted the hospital, which acknowledged the call center problem. Although it took some time, the call center number problem was resolved; however, callers still experience long delays, *e.g.*, 15 minutes or more, reaching an agent.

Other consumers file financial assistance applications with the HEAU because they don't have any information from the hospital about where to send the application. A review of one hospital system's financial assistance policy revealed:

i. The Financial Assistance Policy website did not contain an email address, mailing address, or fax number for submission.

ii. The Corporate Financial Assistance Policy did not contain an email address, mailing address, or fax number for submission. The only contact information noted was the HEAU's contact information. The same policy included a web address that was invalid.

iii. The Patient Information Sheet did not contain an email address, mailing address, or fax number for submission of the financial assistance application. Instead, it included an

inactive web address, a mailing address to appeal a financial assistance determination, and the HEAU's contact information.

iv. The Financial Assistance Checklist did include a mailing address, but not an email address or fax number.

v. The Financial Assistance Contact List included an inactive web address.

The HEAU contacted the hospital system urging the system to include contact information on relevant documents and to correct the bad links contained on the webpages. Many of the HEAU's concerns were addressed by that system, but the HEAU continues to receive applications directly from consumers.

b. Hospitals wrongly assert that Financial Assistance Policies ("FAP") apply only to certain care.

The HEAU was contacted by a national non-profit that helps patients pay off hospital debt about complaints it had received regarding a Maryland hospital's FAP, which states, in part, on the hospital's website: "All Maryland residents or patients, who present with an urgent, emergent, or life-threatening condition, may apply for Financial Assistance." This misleading statement suggests that patients without urgent, emergent, or life-threatening conditions are not entitled to financial assistance. The same hospital has made conflicting and confusing statements suggesting that maternity services are excluded from its FAP as not medically necessary.

Another hospital's Patient Information Sheet states, "[hospital] is committed to ensuring that uninsured patients within its service area who lack financial resources have access to emergency and medically necessary hospital services. If you are unable to pay for medical care, have no other insurance options or sources of payment including Medical Assistance, litigation, or third-party liability, you may qualify for Free or Reduced Cost Medically Necessary Care." This misleading statement suggests that only uninsured patients and patients with no other sources of payment are eligible for financial assistance. We are concerned about these misleading statements and their application and have asked the Health Services Cost Review Commission to address these issues with the hospitals as part of its review of each hospital's implementation and compliance processes.

4. Ongoing Concerns

The HEAU remains concerned about required prepayments of deductibles and coinsurance and failure to refund overpayments, medical records costs, electronic health record errors, abandoned medical records, and assisted living facility resident agreements as reported in the FY 2021 report.

VII. Conclusion

Maryland continues to be a leader and innovator in the health care marketplace. As the marketplace rapidly and significantly evolves, becomes more concentrated, and moves to national online-provider models, and inter-state models (*e.g.*, out-of-state hospitals with in-state facilities), we must ensure that Marylanders are protected from unfair, deceptive, and abusive trade practices.

Appendix

Carrier Cases
Adverse Decisions, Grievances and Outcomes

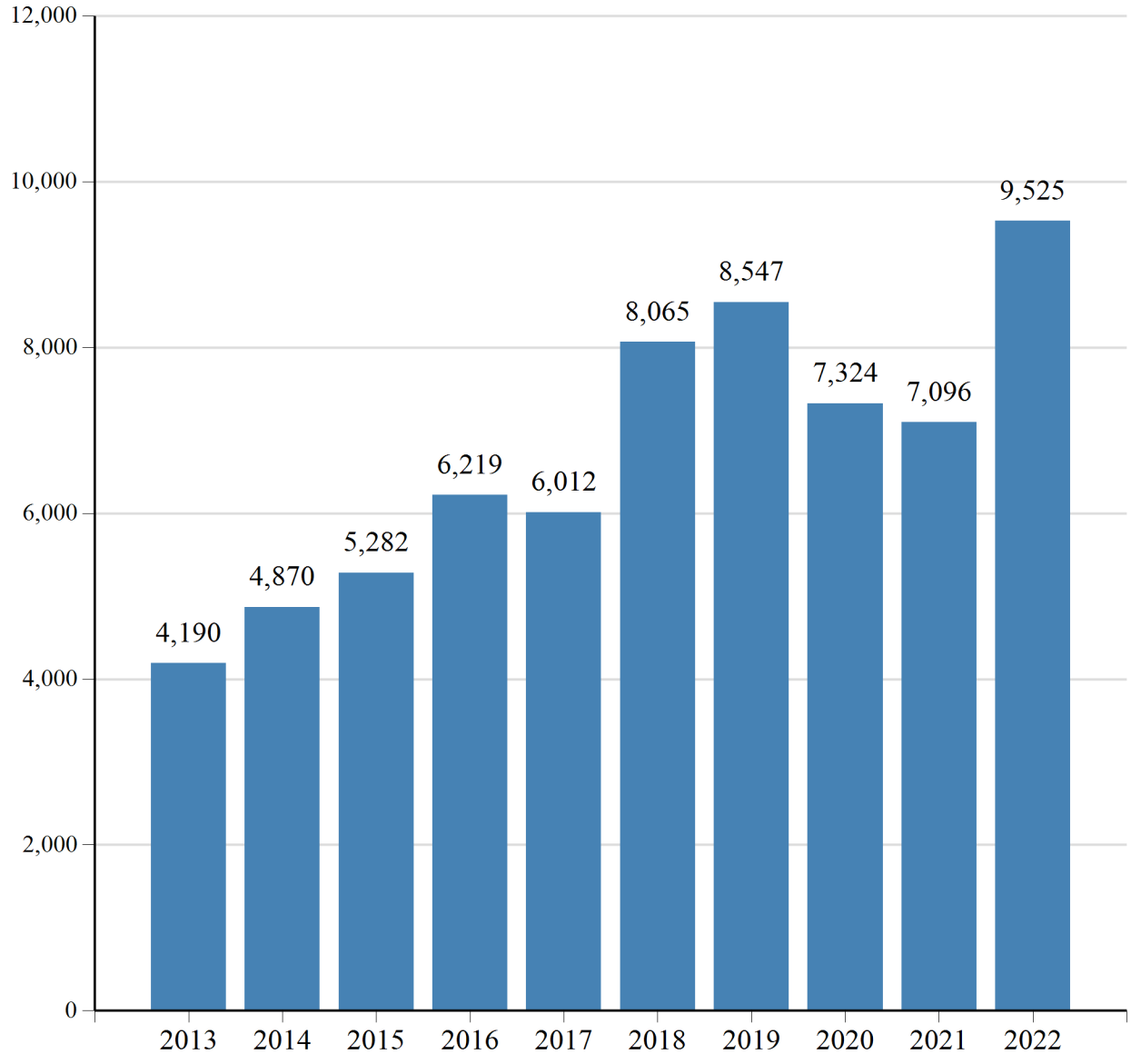
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
4 Ever Life Insurance Company	0	0	9	0%	100%
Aetna Dental Inc.	741	0	1	0%	100%
Aetna Health Inc. (a Pennsylvania corporation)	120	9	239	58%	42%
Aetna Life Insurance Company	248	17	158	53%	47%
Alpha Dental Programs, Inc.	0	0	180	53%	47%
Ameritas Life Insurance Corp.	360	0	128	54%	46%
CareFirst BlueChoice, Inc.	22,816	0	1,883	41%	59%
Carefirst of Maryland, Inc.	8,416	0	1,017	37%	63%
CIGNA Dental Health of Maryland, Inc.	59	0	0	0%	0%
CIGNA Health and Life Insurance Company	17,109	0	637	53%	47%
Connecticut General Life Insurance Company	6	0	0	0%	0%
Delta Dental Insurance Company	10	0	143	64%	36%
Delta Dental of Pennsylvania	70	0	652	65%	35%
Dental Network, Inc.	6	0	0	0%	0%
Dentegra Insurance Company	13	0	78	64%	36%
Dominion Dental Services, Inc.	1,887	0	167	59%	41%
Golden Rule Insurance Company	17	0	5	60%	40%
Group Dental Service of Maryland, Inc.	321	0	1	100%	0%
Group Hospitalization and Medical Services, Inc.	6,715	0	878	37%	63%
Guardian Life Insurance Company of America	1,543	0	814	58%	42%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Independence American Insurance Company	0	0	2	0%	100%
Johns Hopkins HealthCare LLC	86	0	72	65%	35%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	1,026	0	102	74%	26%
Kaiser Permanente Insurance Company	50	0	9	78%	22%
Lincoln National Life Insurance Company	101	34	0	0%	0%
MAMSI Life and Health Insurance Company	1,120	0	88	59%	41%
Metropolitan Life Insurance Company	606	60	36	92%	8%
National Health Insurance Company	3	0	0	0%	0%
Optimum Choice, Inc.	2,904	0	287	50%	50%
Principal Life Insurance Company	676	0	36	81%	19%
Reliance Standard Life Insurance Company	14	0	1	100%	0%
Standard Insurance Company	61	0	16	44%	56%
Starmount Life Insurance Company	24	0	25	80%	20%
Sun Life Assurance Company of Canada	672	0	49	45%	55%
United Concordia Insurance Company	679	0	284	32%	68%
United of Omaha Life Insurance Company	136	30	42	31%	69%
UnitedHealthcare Insurance Company	15,605	0	1,410	36%	64%
UnitedHealthcare of the Mid-Atlantic, Inc.	4,098	0	60	28%	72%
Wellfleet Group LLC	162	0	14	21%	79%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Wellfleet Insurance Company	59	0	2	50%	50%
Totals	**88,539**	**150**	**9,525**	**46%**	**54%**

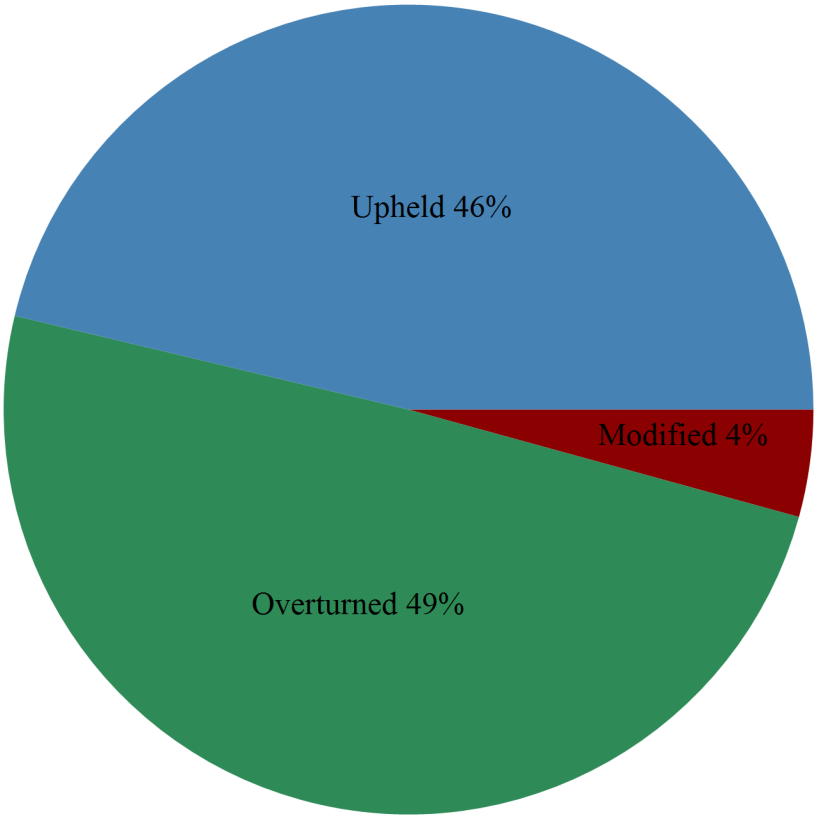
Carrier Grievances Cases
Number of Grievances Over 10 Fiscal Years

The chart below shows the history of the number of grievances filed with carriers under the Appeals and Grievances Law over the last 10 fiscal years.



Carrier Grievances Cases
Outcomes

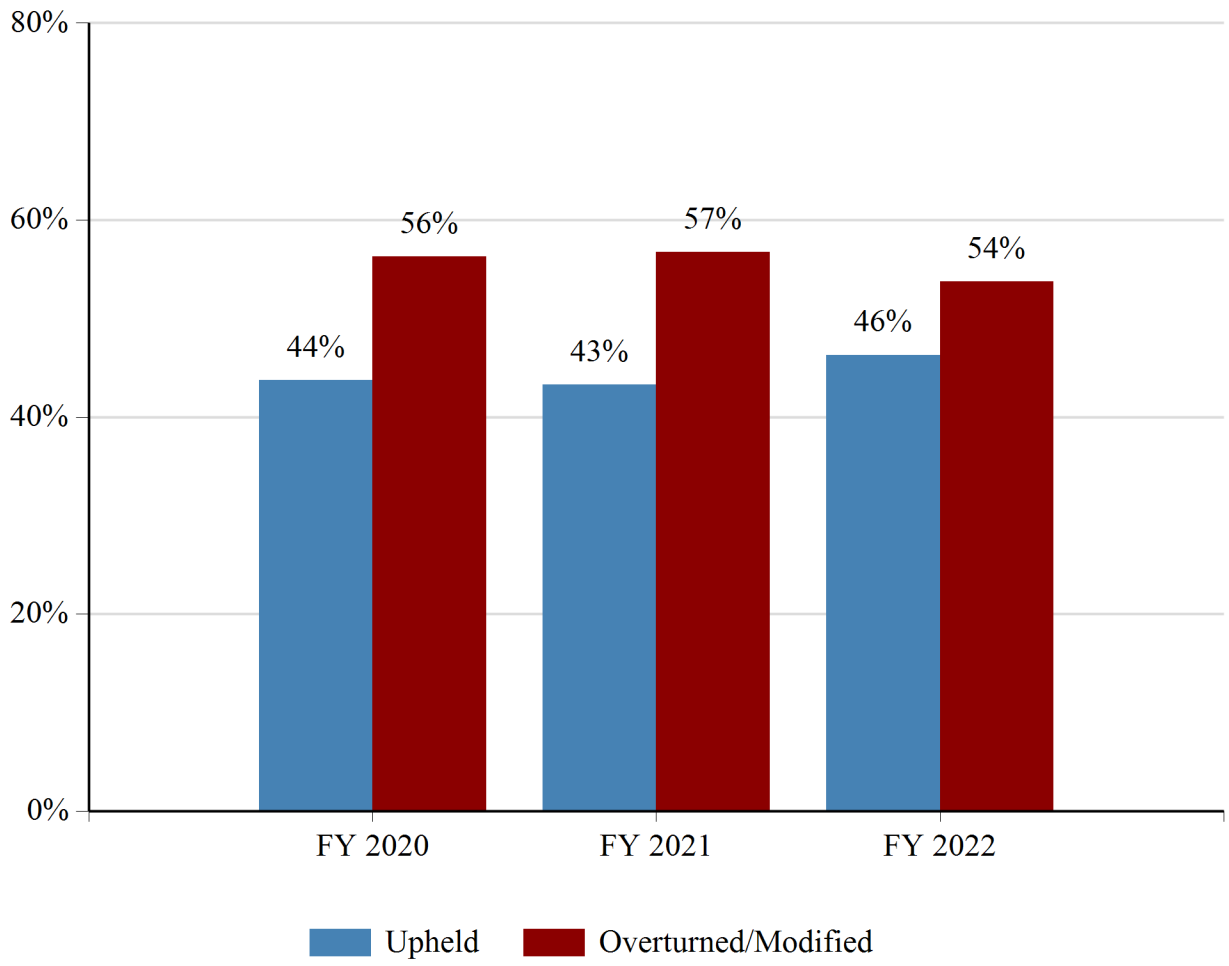
The chart below describes the outcomes of the 9,525 internal grievances filed with carriers in FY 2022, as reported by the carriers.



Percentages may not equal 100% due to rounding.

Carrier Grievances Cases
Three Year Comparison of Outcomes

The chart below compares the year-to-year outcomes of grievances filed with carriers, as reported by the carriers.



Carrier Grievances Cases
Types of Services

Carriers must report the types of services involved in the adverse decisions they issue and the internal grievances they receive. The table below details the types of services involved in the adverse decisions issued and internal grievances filed in FY 2022, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	14,779	16.692%	3,094	32.483%
Durable Medical Equipment	1,239	1.399%	152	1.596%
Emergency Room	40	0.045%	19	0.199%
Home Health	108	0.122%	3	0.031%
Inpatient Hospital	1,289	1.456%	104	1.092%
Laboratory, Radiology	14,862	16.786%	1,139	11.958%
Mental Health / Substance Abuse	620	0.700%	75	0.787%
Other*	862	0.974%	212	2.226%
Pharmacy	46,083	52.048%	4,136	43.423%
Physician	4,730	5.342%	512	5.375%
PT, OT, ST, including inpatient rehabilitation	3,861	4.361%	74	0.777%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	66	0.075%	5	0.052%
Totals	**88,539**	**100%**	**9,525**	**100%**

*"Other" means obesity, IVF, podiatry, hearing and vision.

Carrier Grievances Cases
Outcomes by Service Type

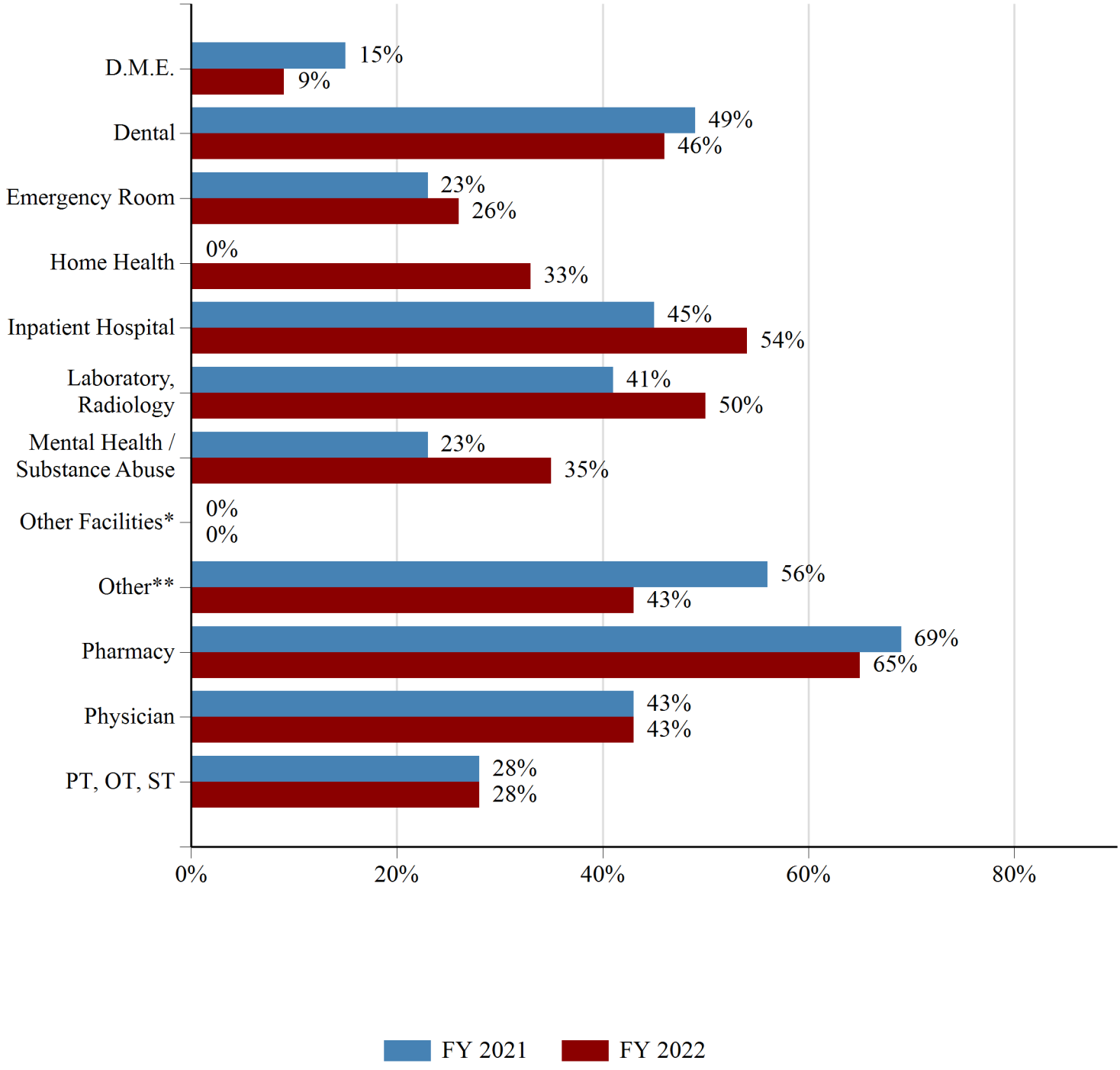
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data. Overturned or modified cases have been combined to more clearly present the data.

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Dental	3,094	54%	46%
Durable Medical Equipment	152	91%	9%
Emergency Room	19	74%	26%
Home Health	3	67%	33%
Inpatient Hospital	104	46%	54%
Laboratory, Radiology	1,139	50%	50%
Mental Health / Substance Abuse	75	65%	35%
Other*	212	57%	43%
Pharmacy	4,136	35%	65%
Physician	512	57%	43%
PT, OT, ST, including inpatient rehabilitation	74	72%	28%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	5	100%	0%
Totals	**9,525**	**46%**	**54%**

*"Other" means obesity, IVF, podiatry, hearing and vision.

Carrier Grievances Cases
Two Year Comparison by Service Type

The chart below compares the percentages of grievances carriers overturned or modified by types of services, comparing FY 2021 and FY 2022.

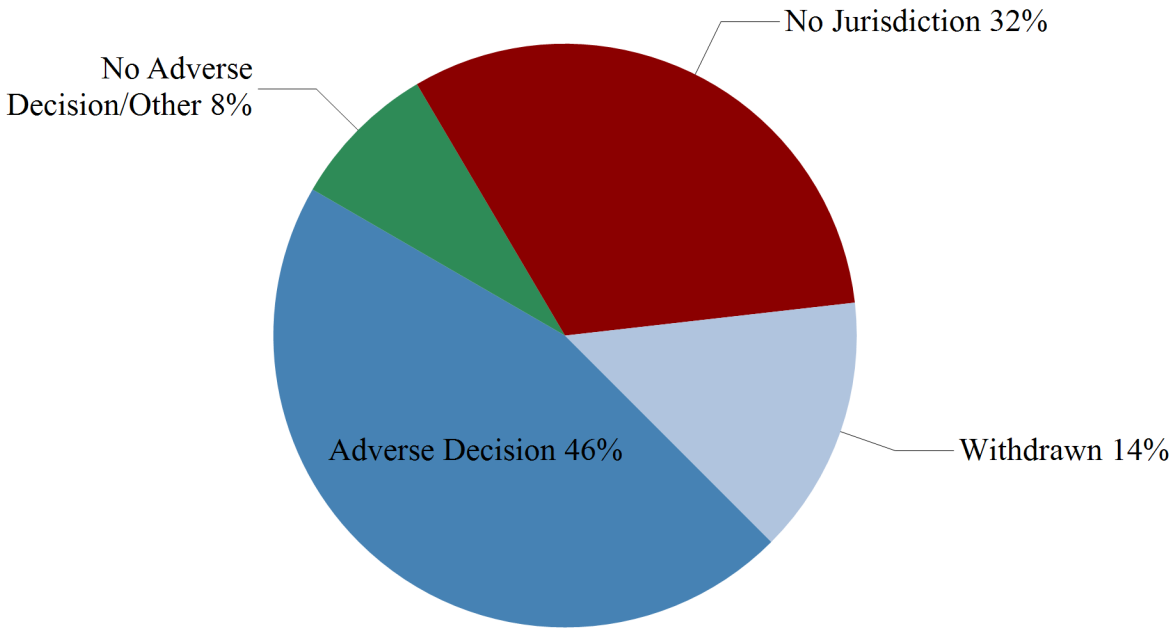


* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.
** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints
Initial Review of Cases

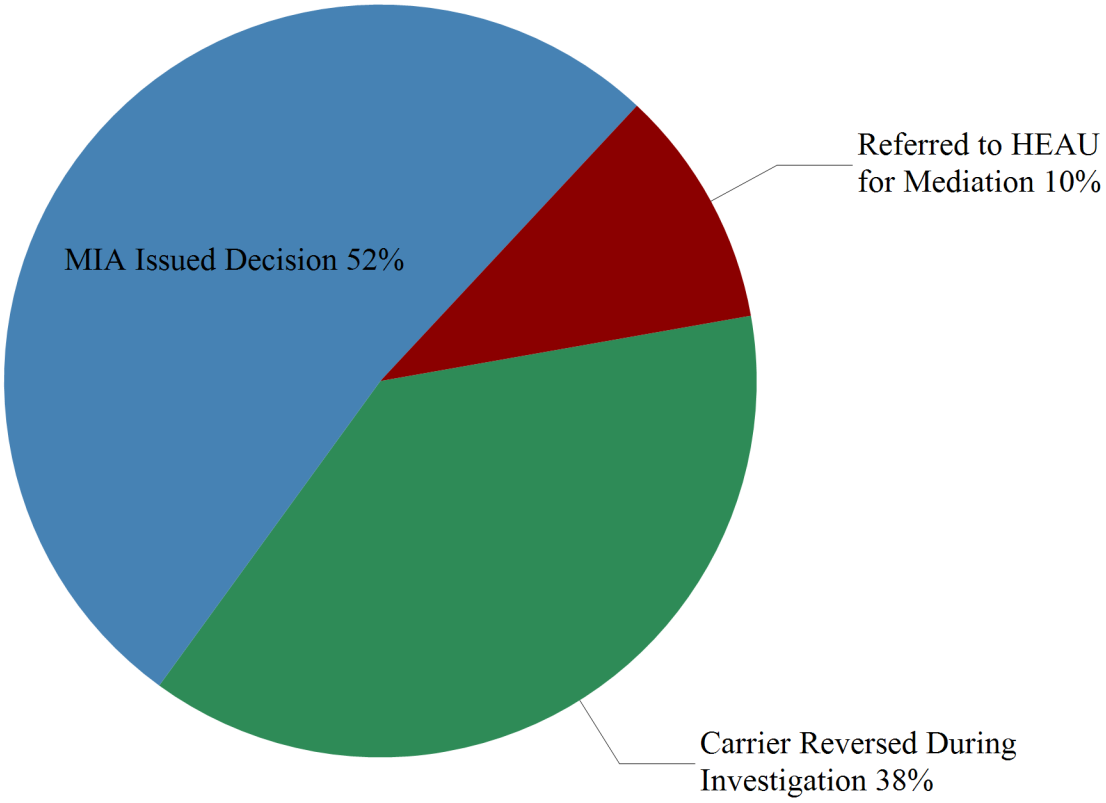
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some complaints to the MIA are withdrawn or there is not enough information to complete the review.

The chart below details the initial disposition of the 783 cases filed with the MIA's Appeals and Grievances Unit during FY 2022.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2022, the MIA determined that 360 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 37 cases to the HEAU where the patient had not exhausted the carrier's internal grievance process. The remaining cases resulted in the carriers reversing their decisions or the MIA issuing a decision. The chart below details the initial disposition of the 360 grievances the MIA reviewed during FY 2022.



MIA Appeals and Grievances Cases
Carriers and Disposition

The table below details the outcomes of the 323 grievances complaints the MIA investigated during FY 2022. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

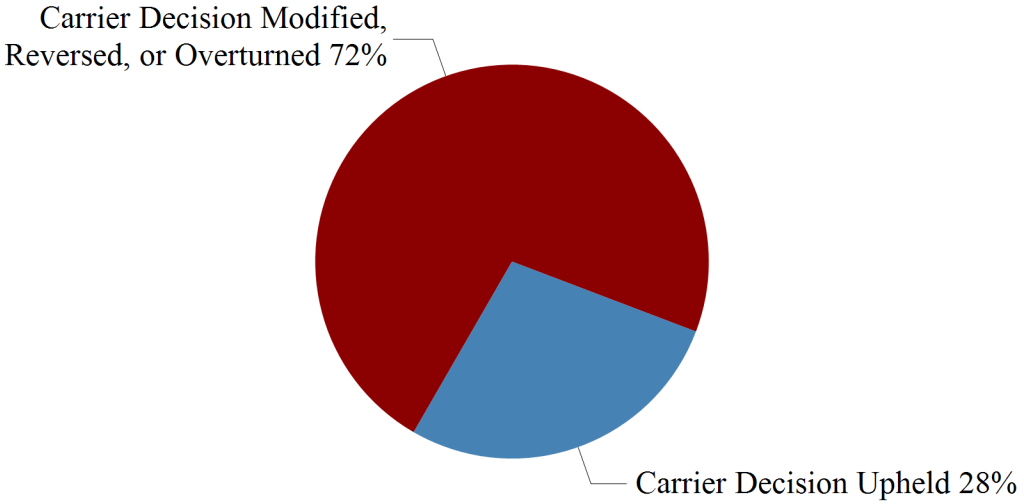
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	5	2	40.0%	1	20.0%	0	0.0%	2	40.0%
Aetna Health Insurance Company	3	1	33.3%	2	66.7%	0	0.0%	0	0.0%
Aetna Life Insurance Company	5	2	40.0%	0	0.0%	0	0.0%	3	60.0%
Ameritas Life Insurance Corp.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
CareFirst BlueChoice, Inc.	87	25	28.7%	27	31.0%	1	1.1%	34	39.1%
Carefirst of Maryland, Inc.	75	18	24.0%	30	40.0%	0	0.0%	27	36.0%
CaremarkPCS Health L.L.C.	4	0	0.0%	2	50.0%	0	0.0%	2	50.0%
CIGNA Health and Life Insurance Company	7	3	42.9%	3	42.9%	0	0.0%	1	14.3%
Delta Dental Insurance Company	2	0	0.0%	0	0.0%	1	50.0%	1	50.0%
Delta Dental of Pennsylvania	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Dominion Dental Services, Inc.	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
Group Hospitalization and Medical Services, Inc.	22	7	31.8%	9	40.9%	0	0.0%	6	27.3%
Guardian Life Insurance Company of America	13	7	53.8%	1	7.7%	0	0.0%	5	38.5%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	13	5	38.5%	1	7.7%	0	0.0%	7	53.8%
MAMSI Life and Health Insurance Company	3	1	33.3%	0	0.0%	0	0.0%	2	66.7%
Optimum Choice, Inc.	4	0	0.0%	3	75.0%	0	0.0%	1	25.0%

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Principal Life Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
UnitedHealthcare Insurance Company	71	15	21.1%	15	21.1%	1	1.4%	40	56.3%
UnitedHealthcare of the Mid-Atlantic, Inc.	4	1	25.0%	1	25.0%	0	0.0%	2	50.0%
Totals	**323**	**89**	**28%**	**95**	**29%**	**3**	**1%**	**136**	**42%**

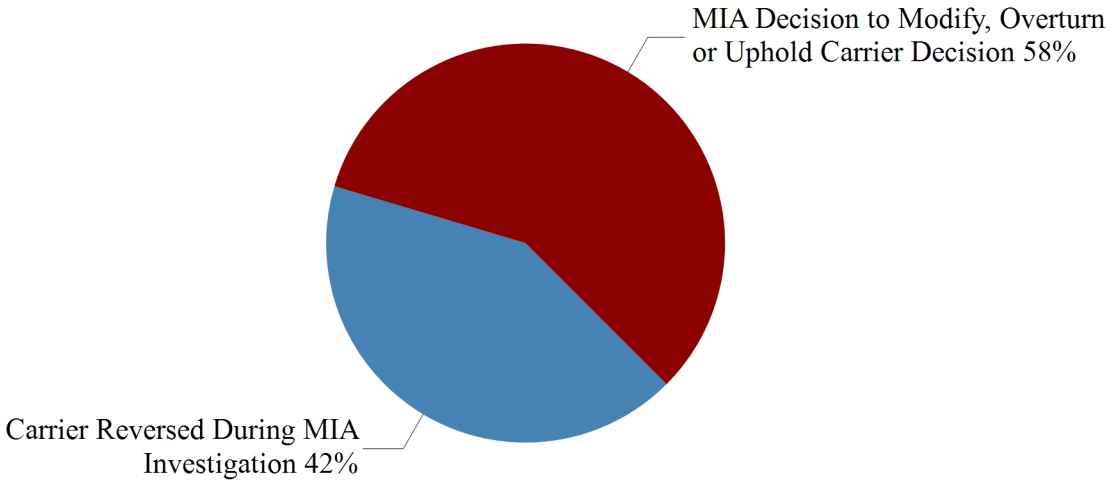
Percentages may not equal 100% due to rounding.

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 323 grievances the MIA investigated during FY 2022.

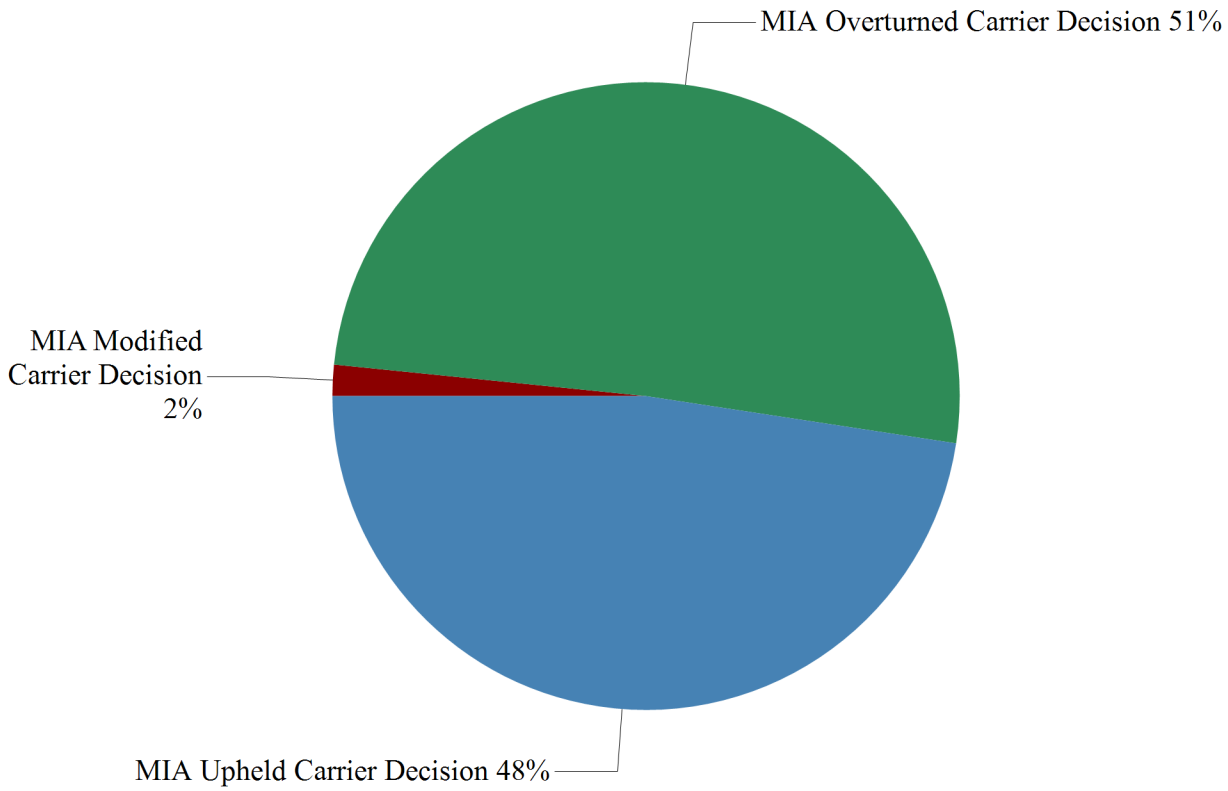


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 187 cases the MIA forwarded to an IRO for review in FY 2022.



Percentages may not equal 100% due to rounding.

MIA Appeals and Grievances Cases
Types of Services Denied and Outcomes

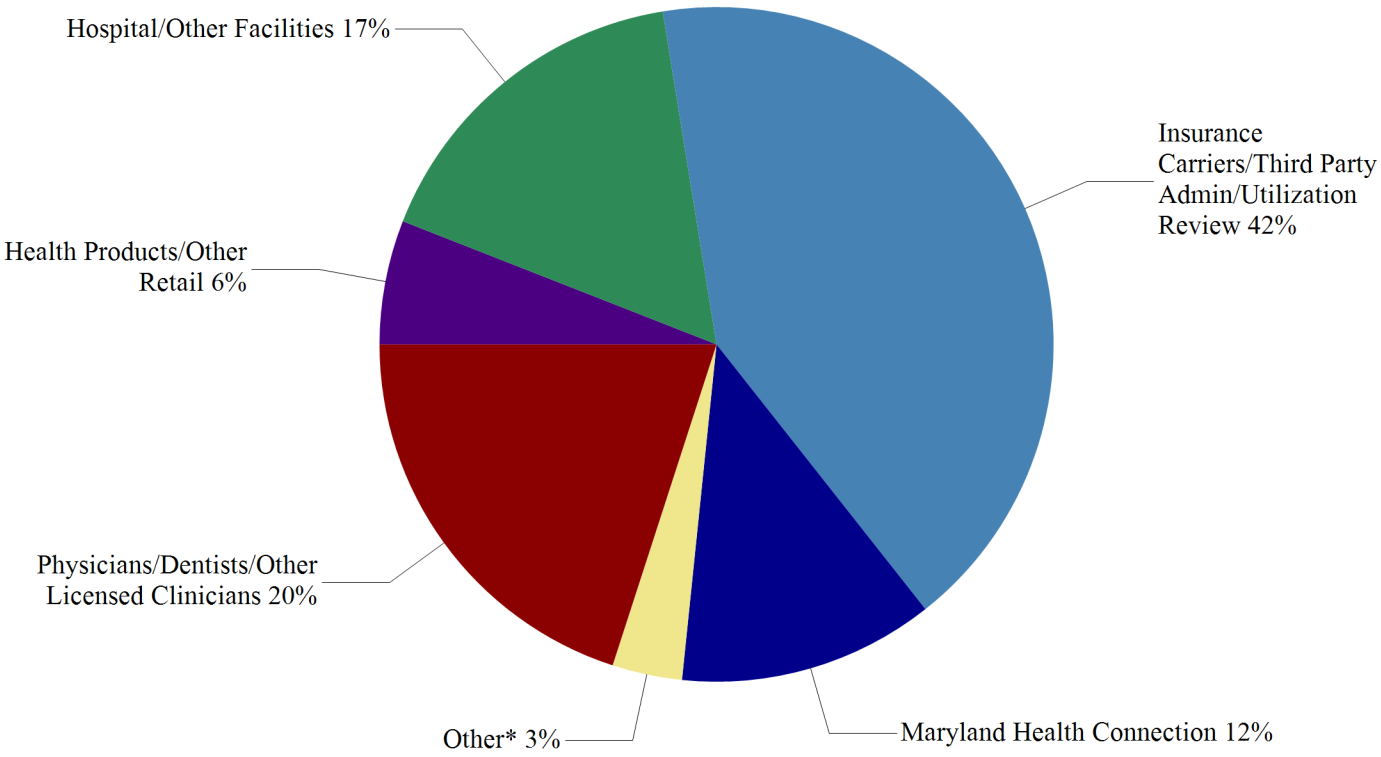
The table below identifies the types of services involved in grievances the MIA investigated during FY 2022. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Air Ambulance	1	<1 %	1	100%	0	0%	0	0%	0	0%
Cosmetic	2	<1 %	1	50%	1	50%	0	0%	0	0%
Dental Care Services	30	9%	10	33%	3	10%	1	3%	16	53%
Durable Medical Equipment	6	2%	2	33%	3	50%	0	0%	1	17%
Emergency Room Denial	2	<1 %	0	0%	0	0%	0	0%	2	100%
Experimental	10	3%	6	60%	2	20%	0	0%	2	20%
Eye Care Services	1	<1 %	0	0%	1	100%	0	0%	0	0%
Home Care Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
In-Patient Rehabilitation Services	3	<1 %	1	33%	0	0%	0	0%	2	67%
Lab, Imaging, Test Services	56	17%	24	43%	24	43%	0	0%	8	14%
Mental Health Partial Hospitalization	1	<1 %	0	0%	0	0%	0	0%	1	100%
Mental Health/Substance Abuse (Inpatient) Services	2	<1 %	0	0%	0	0%	0	0%	2	100%
Mental Health/Substance Abuse (Outpatient) Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Out-of-Network Benefits	1	<1 %	1	100%	0	0%	0	0%	0	0%
Pharmacy Services/Formulary Issues	163	50%	27	17%	52	32%	1	1%	83	51%
Physician Services	40	12%	16	40%	9	23%	1	3%	14	35%
PT, OT, ST Services	3	<1 %	0	0%	0	0%	0	0%	3	100%
Totals	**323**	**100%**	**89**	**28%**	**95**	**29%**	**3**	**1%**	**136**	**42%**

Percentages may not equal 100% due to rounding.

HEAU Cases
Subject of Complaints

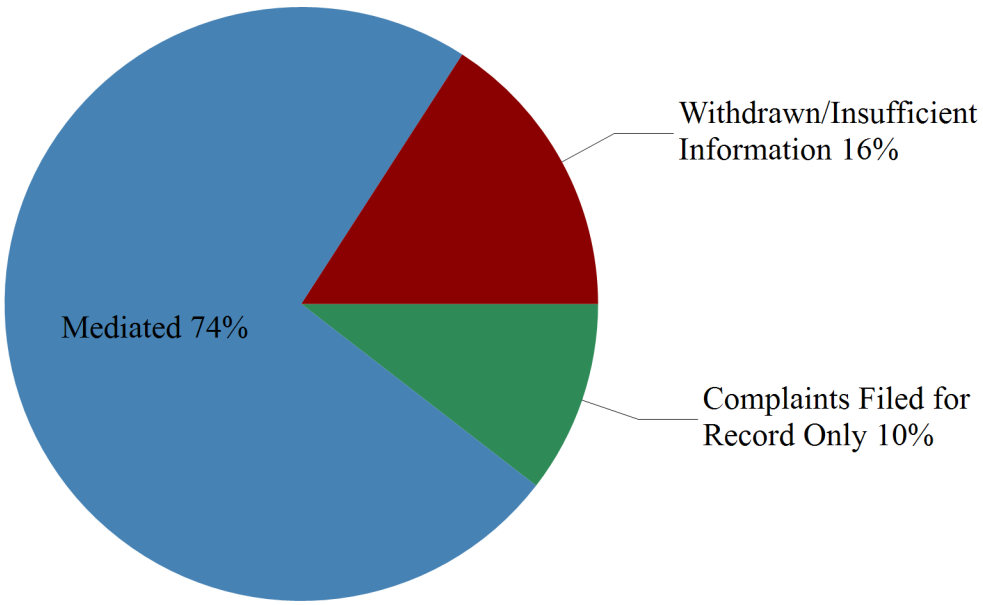
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, and various other issues encountered in the health care marketplace. In addition, the HEAU assists consumers who experience enrollment difficulties on Maryland Health Connection. The chart below illustrates the types of industries involved in the cases the HEAU closed during FY 2022. The HEAU closed 1,695 complaints. Some complaints were filed against more than one industry.



* "Other" includes Collection/Billing Entities, Ambulance, Government Agency, Employer and other non-specific categories (e.g. HSA/FSA).

HEAU Appeals and Grievances Cases
Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Some consumers, or other persons, file complaints but never complete an authorization to release medical records, a form required by the HEAU to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. The chart below details the initial disposition of the 592 Appeals and Grievances cases closed by the HEAU during FY 2022.



HEAU Mediated Appeals and Grievances Cases
Carriers, Regulatory Authority and Disposition

The table below identifies the names of the carriers and the outcomes of the Appeals and Grievances cases mediated and closed by the HEAU during FY 2022. "Carriers" are defined in this report to include insurers, nonprofit health service plans, HMOs, dental plans, third-party administrators, utilization review agents, pharmaceutical benefit management companies, and any other entity that provides health benefit plans or adjudicates claims. Some complaints involved more than one carrier; the HEAU mediated and closed 436 cases in FY 2022. Maryland Health Connection is listed as a carrier in cases where the appeal or grievance involved a dispute that required both the carrier and Maryland Health Connection to act to resolve the dispute.

Carrier	Total Cases	Upheld		Overturned/Modified	
Aetna Health Inc.					
State Regulated	6	1	17%	5	83%
Not State Regulated	24	9	38%	15	63%
Total Complaints	**30**	**10**	**33%**	**20**	**67%**
AIM Specialty Health					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
AMWINS Connect Administrators					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Anthem Blue Cross and Blue Shield					
Not State Regulated	10	7	70%	3	30%
Total Complaints	**10**	**7**	**70%**	**3**	**30%**
APWU Health Plan					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Bind Benefits, Inc.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Blue Cross Blue Shield of Illinois					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Blue Cross Blue Shield of Michigan					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Blue Cross Blue Shield of Texas					
Not State Regulated	3	1	33%	2	67%
Total Complaints	**3**	**1**	**33%**	**2**	**67%**
BlueCross BlueShield of Illinois					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
BlueCross BlueShield of North Carolina					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
CareFirst					
State Regulated	102	33	32%	69	68%
Not State Regulated	57	19	33%	38	67%
Total Complaints	**159**	**52**	**33%**	**107**	**67%**
CareFirst Administrators					
Not State Regulated	12	10	83%	2	17%
Total Complaints	**12**	**10**	**83%**	**2**	**17%**
CareFirst the Dental Network					
State Regulated	6	0	0%	6	100%
Not State Regulated	3	0	0%	3	100%
Total Complaints	**9**	**0**	**0%**	**9**	**100%**
CIGNA					
State Regulated	6	3	50.0%	3	50.0%
Not State Regulated	30	14	47%	16	53%
Total Complaints	**36**	**17**	**47%**	**19**	**53%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Cigna Dental					
State Regulated	4	1	25%	3	75%
Not State Regulated	2	2	100%	0	0%
Total Complaints	**6**	**3**	**50%**	**3**	**50%**
Companion Life Insurance Company					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Conifer Health Solutions					
Not State Regulated	4	2	50%	2	50%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**
CVS Caremark					
State Regulated	6	2	33%	4	67%
Not State Regulated	16	7	44%	9	56%
Total Complaints	**22**	**9**	**41%**	**13**	**59%**
Delta Dental					
State Regulated	2	1	50%	1	50%
Not State Regulated	5	3	60%	2	40%
Total Complaints	**7**	**4**	**57%**	**3**	**43%**
Delta Dental of Michigan					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Delta Dental of Missouri					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Dominion National					
State Regulated	2	0	0%	2	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
EpiphanyRx, LLC					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
eviCore Healthcare					
State Regulated	1	0	0%	1	100%
Not State Regulated	4	1	25%	3	75%
Total Complaints	**5**	**1**	**20%**	**4**	**80%**
Express Scripts					
Not State Regulated	7	2	29%	5	71%
Total Complaints	**7**	**2**	**29%**	**5**	**71%**
FELRA & UFCW Health and Welfare Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Freedom Life Insurance Company of America					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Golden Rule Insurance					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Government Employees Health Association (GEHA)					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Group Benefit Services, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Guardian Life insurance Company of America					
State Regulated	5	1	20%	4	80%
Not State Regulated	3	1	33%	2	67%
Total Complaints	**8**	**2**	**25%**	**6**	**75%**
Healthgram, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

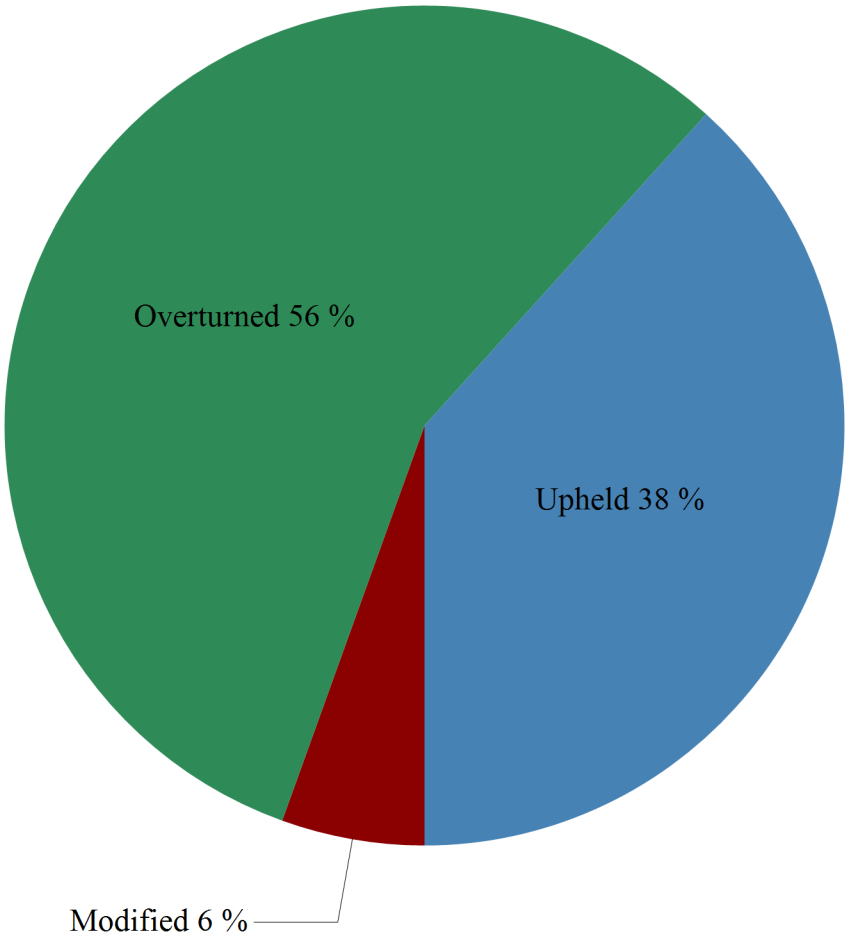
Carrier	Total Cases	Upheld		Overturned/Modified	
HealthSCOPE Benefits					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Highmark BlueCross BlueShield					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Humana Medicare Appeals					
Not State Regulated	5	3	60%	2	40%
Total Complaints	**5**	**3**	**60%**	**2**	**40%**
Johns Hopkins Advantage MD					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Johns Hopkins Employer Health Programs					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	14	9	64%	5	36%
Not State Regulated	3	1	33%	2	67%
Total Complaints	**17**	**10**	**59%**	**7**	**41%**
Key Benefit Administrators					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Maryland Health Connection					
State Regulated	10	1	10%	9	90%
Total Complaints	**10**	**1**	**10%**	**9**	**90%**
MDIPA | UnitedHealthcare					
Not State Regulated	6	2	33%	4	67%
Total Complaints	**6**	**2**	**33%**	**4**	**67%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Metropolitan Life Insurance Company					
State Regulated	1	0	0%	1	100%
Not State Regulated	4	0	0%	4	100%
Total Complaints	**5**	**0**	**0%**	**5**	**100%**
National Association of Letter Carriers Health Benefit Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
National General Accident & Health					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Optum					
State Regulated	2	2	100%	0	0%
Not State Regulated	2	1	50%	1	50%
Total Complaints	**4**	**3**	**75%**	**1**	**25%**
OptumRx					
State Regulated	1	0	0%	1	100%
Not State Regulated	2	0	0%	2	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
Principal Life Insurance Company					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
SilverScript					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Steamfitter's Local 602 Medical Fund					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
The Loomis Company					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
UMR					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
United Concordia Insurance Company					
Not State Regulated	13	7	54%	6	46%
Total Complaints	**13**	**7**	**54%**	**6**	**46%**
UnitedHealthcare					
State Regulated	26	10	38%	16	62%
Not State Regulated	39	19	49%	20	51%
Total Complaints	**65**	**29**	**45%**	**36**	**55%**
Warehouse Employee Union Health And Welfare Fund					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Zelis					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

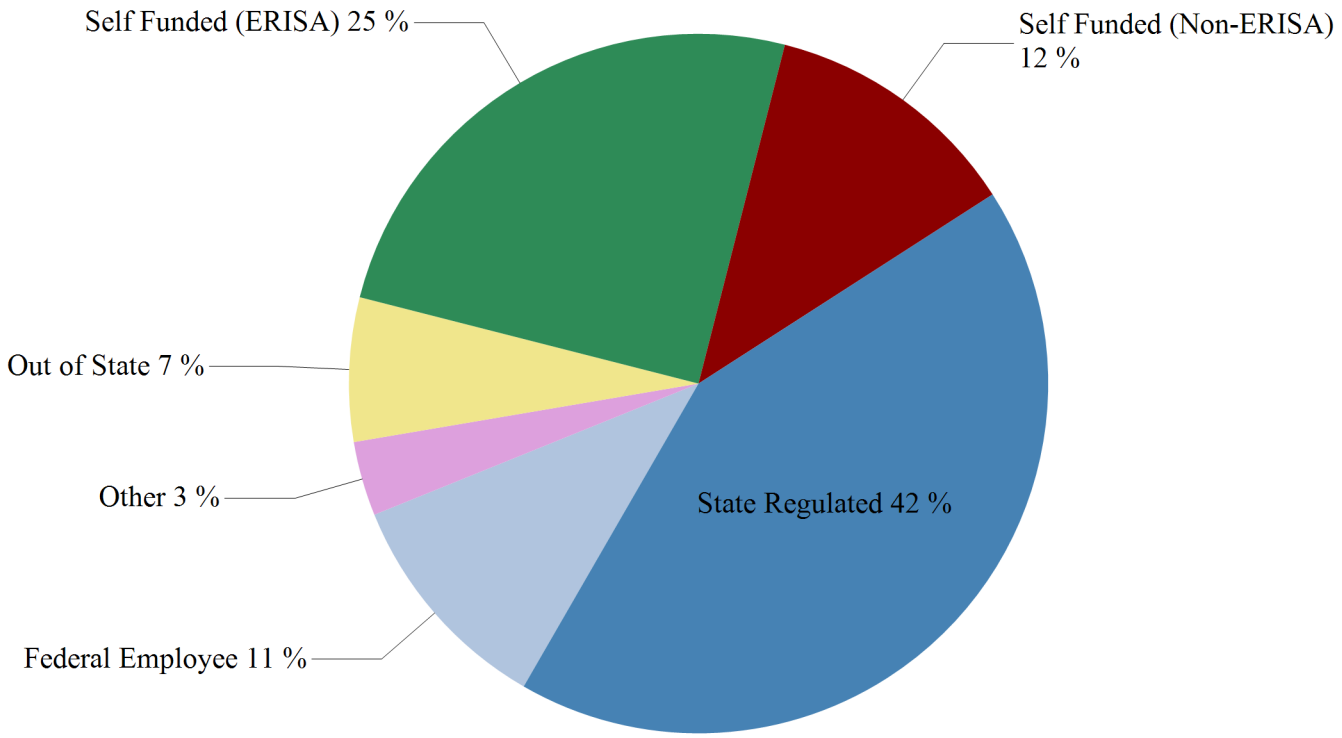
HEAU Mediated Appeals and Grievances Cases
Disposition

Carriers may uphold, overturn, or modify their decisions during the appeals and grievances process. The chart below identifies the outcomes of the Appeals and Grievances cases that the HEAU mediated and closed during FY 2022.



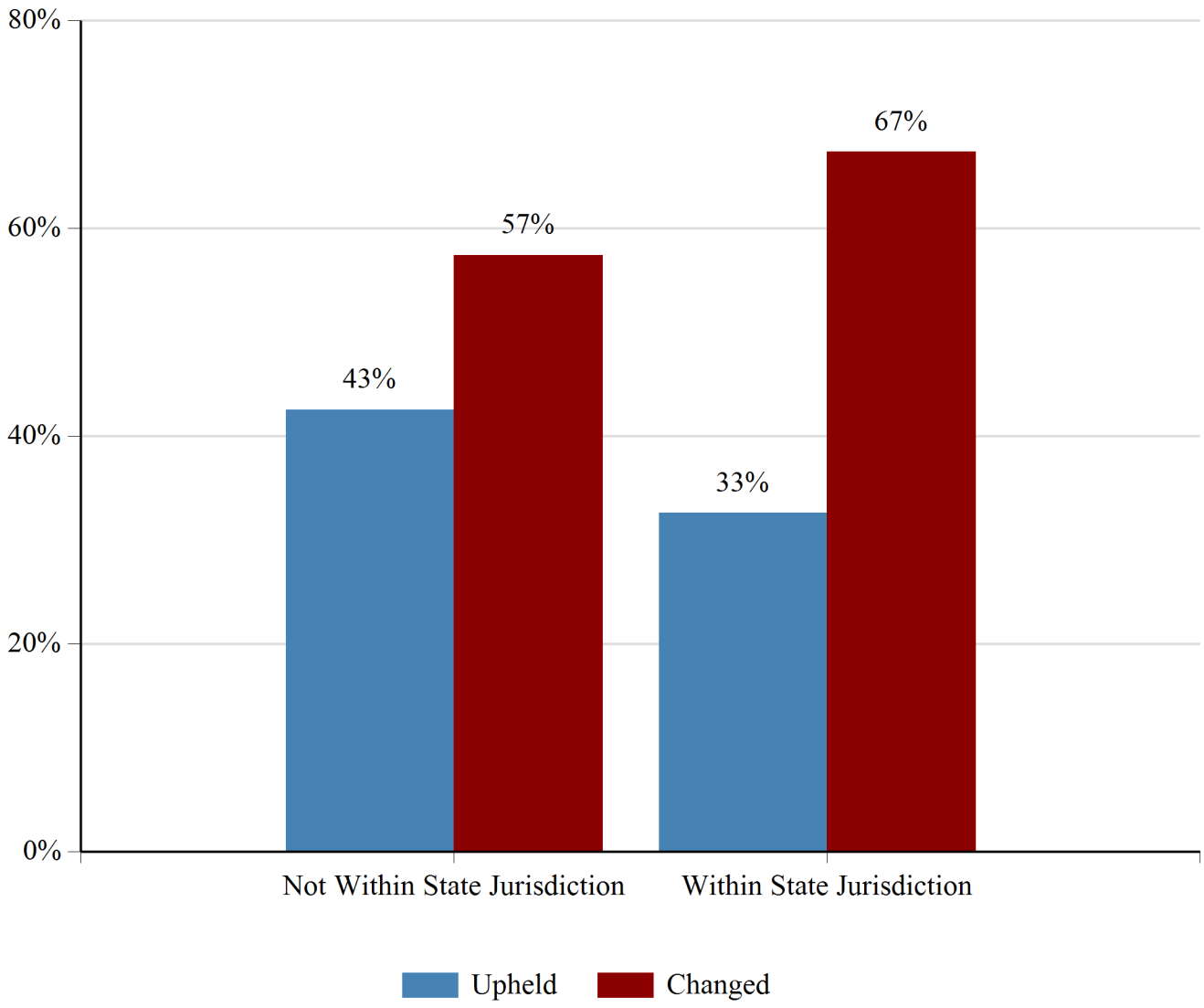
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the primary carrier types involved in the 436 Appeals and Grievances cases the HEAU mediated and closed during FY 2022.



HEAU Mediated Appeals and Grievances Cases
Outcomes Based on MIA Regulatory Authority

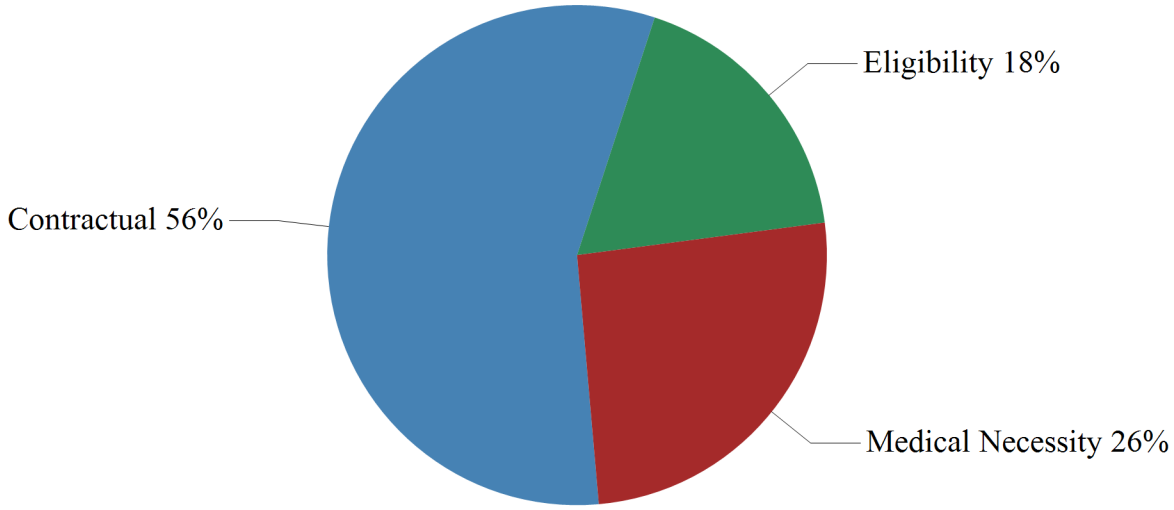
The chart below reflects the outcomes of the 436 Appeals and Grievances cases the HEAU mediated and closed during FY 2022 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

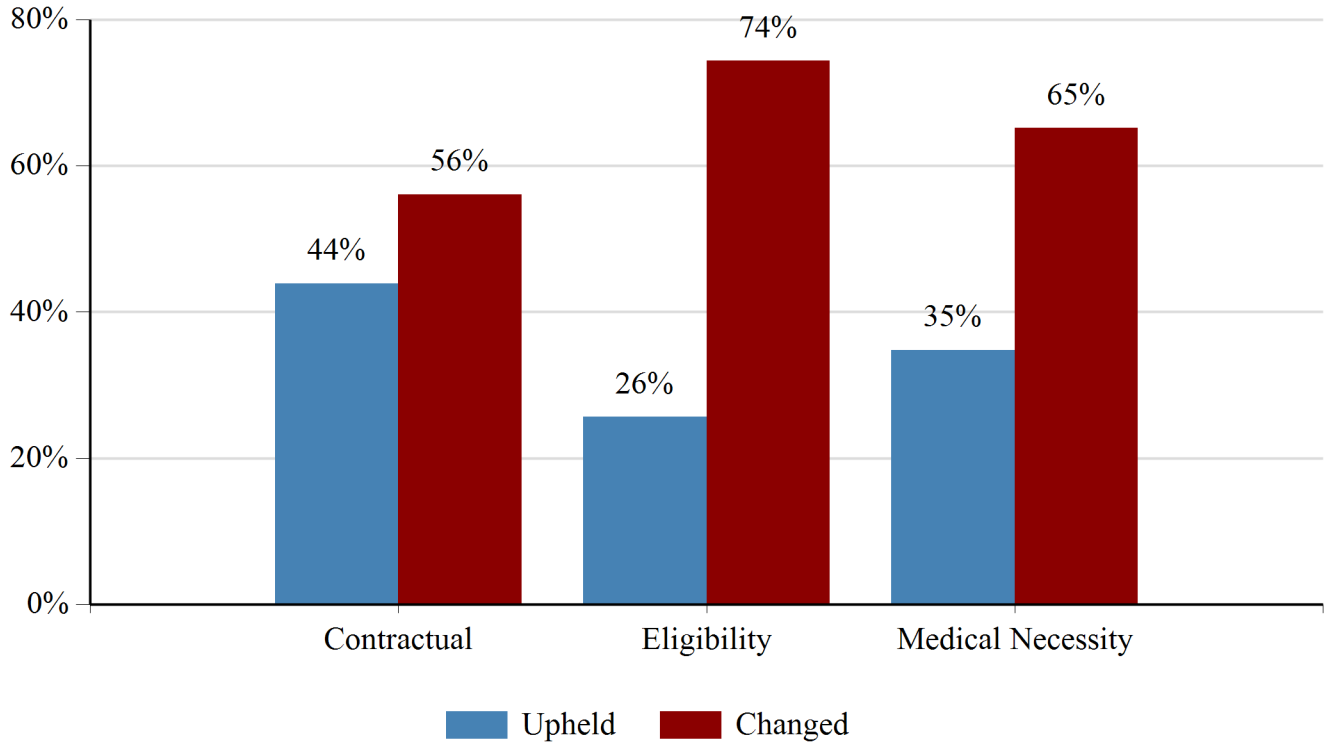
Types of Denials

The HEAU reports data on medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions). The chart below identifies the percentages of each type of case the HEAU mediated and closed during FY 2022.



Outcomes by Denial Type

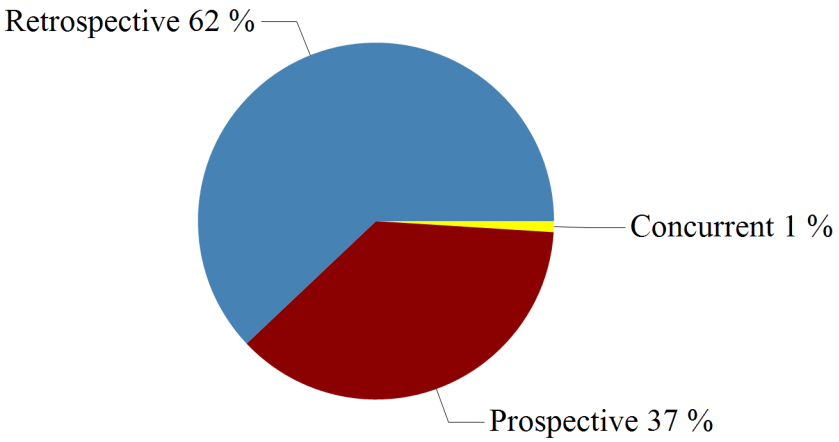
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2022.



HEAU Mediated Appeals and Grievances Cases

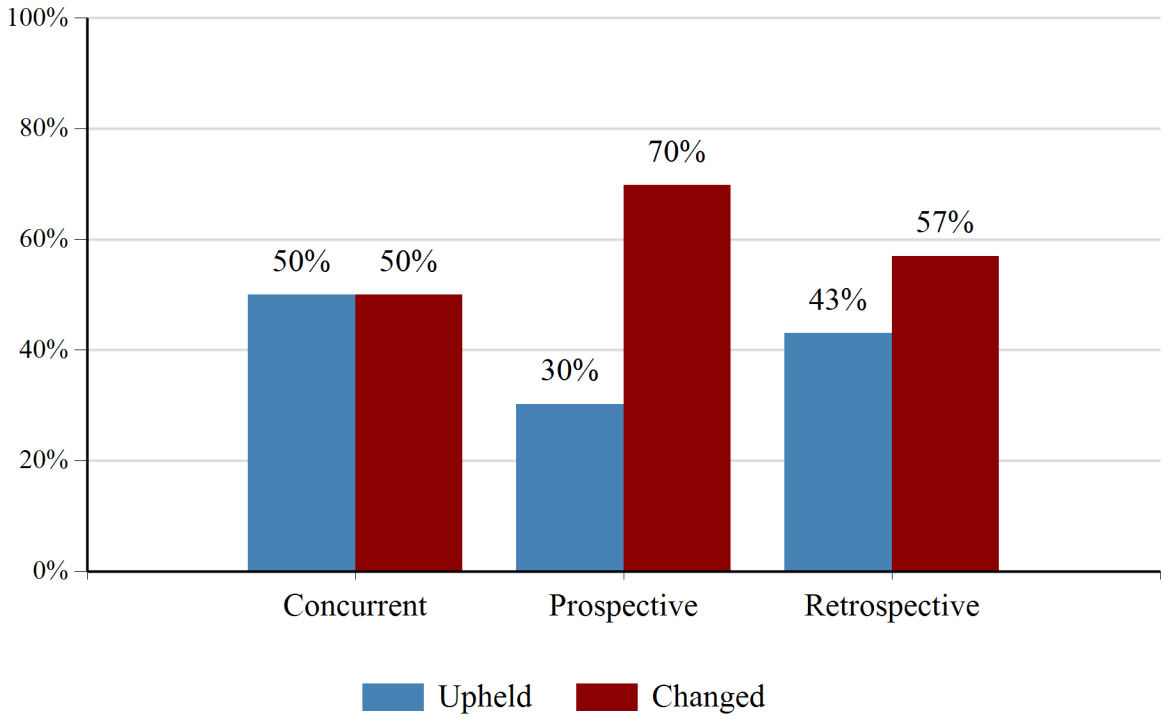
Timing of Denials

Carriers can deny coverage prior to a provider rendering a service, while a provider is rendering a service, or after a provider renders a service. The chart below identifies the timing of carrier denials for each type of Appeals and Grievances case the HEAU mediated and closed during FY 2022. Eligibility disputes are treated as prospective denials.



Outcomes by Timing of Denials

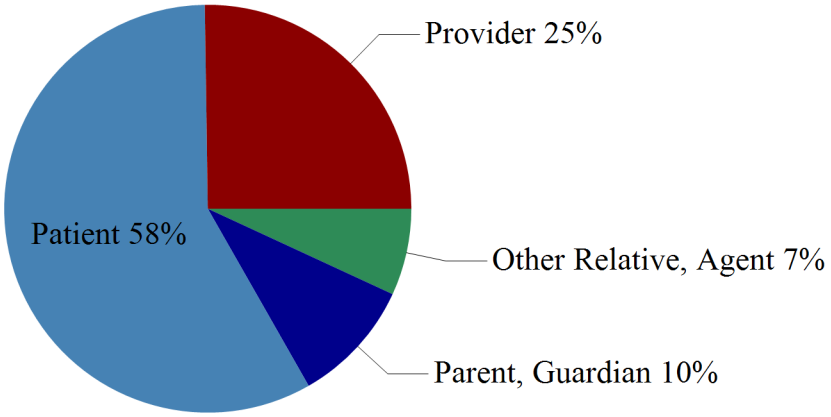
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2022 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

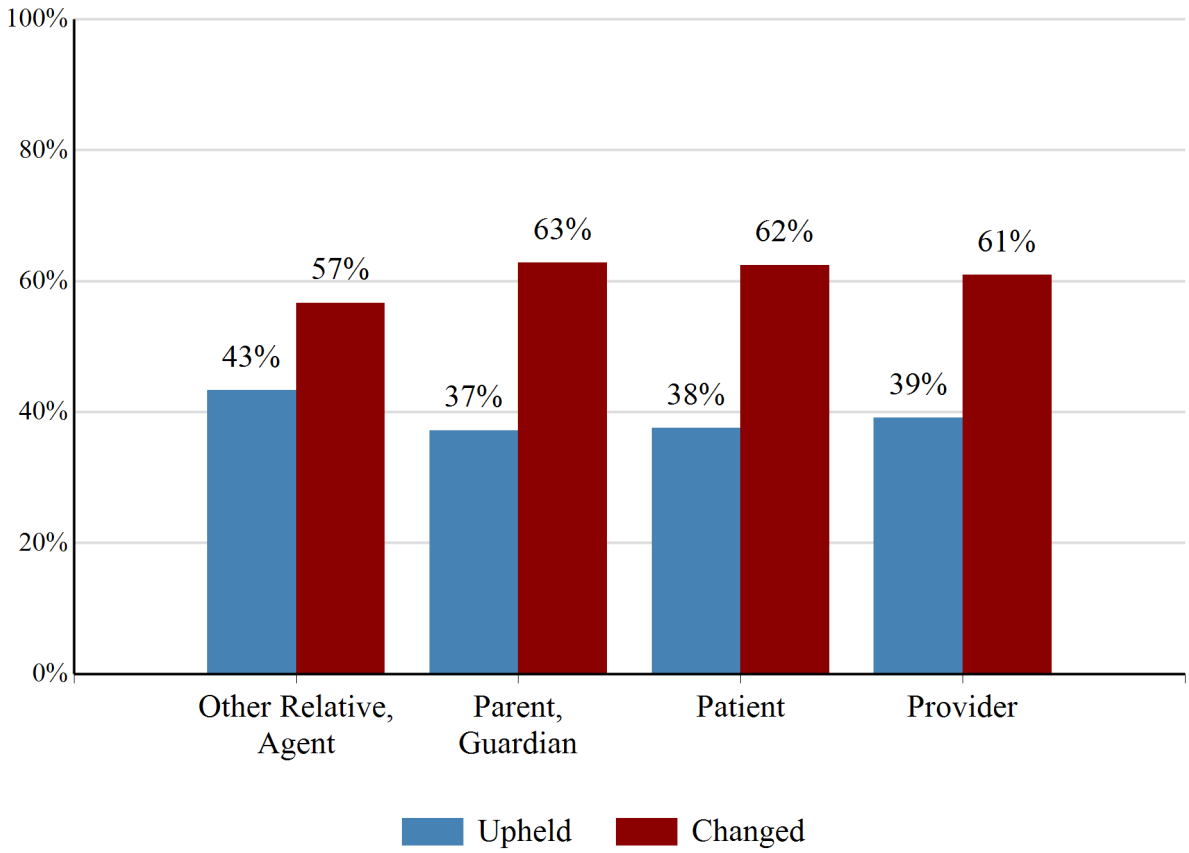
Who Filed the Case

Complaints may be filed by patients or filed on behalf of patients by providers, parents, other relatives, or other agents. The chart below shows who filed Appeals and Grievances cases the HEAU mediated and closed during FY 2022.



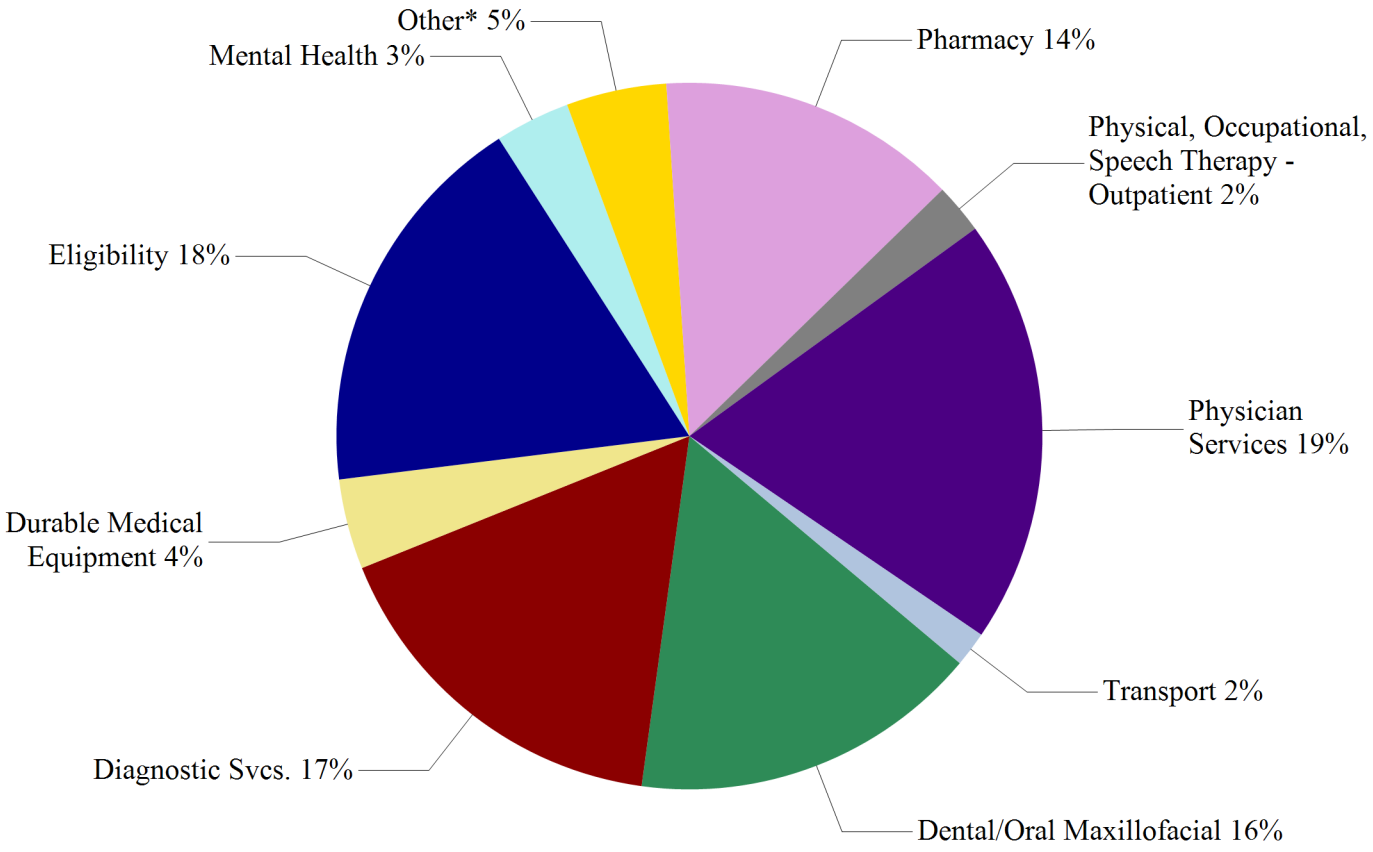
Outcomes by Who Filed the Case

The chart below reflects the outcomes, in relation to who filed the complaint, of the Appeals and Grievances cases the HEAU mediated and closed during FY 2022.



HEAU Mediated Appeals and Grievances Cases
Types of Services Denied

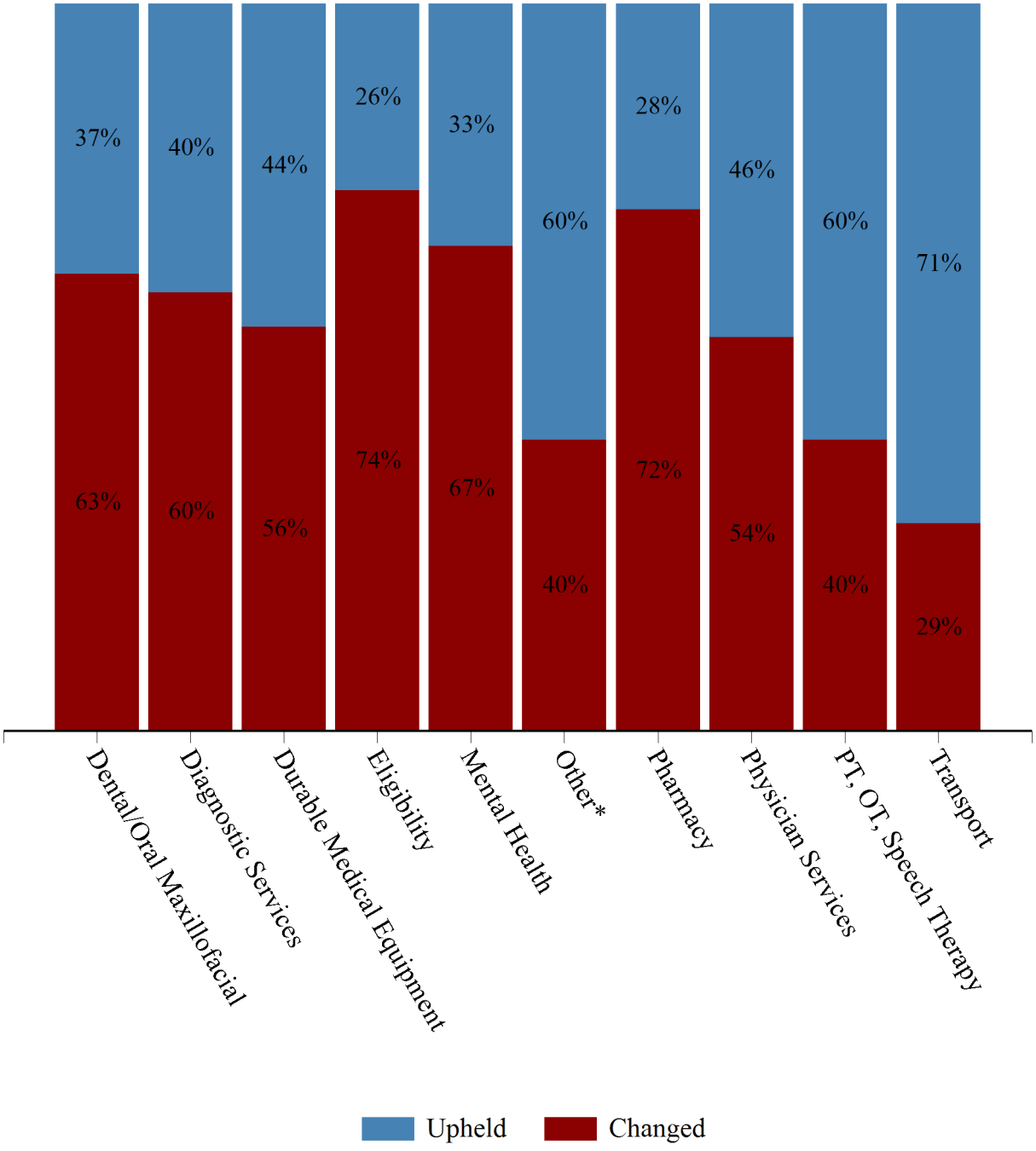
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2022.



* "Other" includes acupuncture, chiropractic, emergency room, hospital length of stay, inpatient physical rehabilitation, optometry, products and supplements and skilled nursing facility.

HEAU Mediated Appeals and Grievances Cases
Outcomes by Service Type

The chart below compares the outcomes of the Appeals and Grievances cases the HEAU mediated and closed during FY 2022 based on the types of services denied.



* "Other" includes acupuncture, chiropractic, emergency room, hospital length of stay, inpatient physical rehabilitation, optometry, products and supplements and skilled nursing facility.