State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

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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 2023, beginning July 1, 2022, and concluding June 30, 2023.

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 and legislative recommendations to strengthen consumer protections in the health care marketplace.

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

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

[2] The Appeals and Grievances Law currently defines "carrier" as a person that offers a health benefit plan and is: (1) an authorized issuer that provides health insurance in the State; (2) a nonprofit health service plan; (3) a health maintenance organization; (4) a dental plan organization; (5) a self-funded student health plan operated by an independent institution of higher education…that provides health care to its students and their dependents; or, (6) except for a managed care organization… any other person that provides health benefit plans subject to regulation by the State. Md. Code Ann., Insurance 15-10A-01(c).

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

enacted Chapters 3 and 4,[4] which expanded the definition of "coverage decisions" to include 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 2023, 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, 2023, the external review process 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

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

[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).

coverage (whether or not the rescission has any effect on any particular benefit at that time).

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.

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.

- 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 last two bullets provide perhaps the most important limitations on using the data to ensure carrier accountability to the Appeals and Grievances law. For this reason, 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 2023

In addition to the highlights below, statistical details from the data submitted by carriers appear in charts on pages 16-23 of this report.

1. Carriers reported 135,922 adverse decisions in FY 2023, 47,383 more adverse decisions than reported in FY 2022. Many carriers increased the number of adverse decisions issued in FY 2023 over FY 2022. Notably, in FY 2023, for carriers that reported more than 1,000 adverse decisions:

    - CareFirst BlueChoice, Inc. issued 24% more adverse decisions than in FY 2022;
    - CareFirst of Maryland, Inc. issued 23% more adverse decisions than in FY 2022;
    - Dominion Dental Services, Inc. issued 31% more adverse decisions than in FY 2022;
    - Group Hospitalization and Medical Services, Inc. issued 20% more adverse decisions than in FY 2022;
    - Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. issued 59% more adverse decisions than in FY 2022;
    - MAMSI Life and Health Insurance Company issued 495% more adverse decisions than in FY 2022;
    - Optimum Choice, Inc. issued 190% more adverse decisions than in FY 2022; and
    - UnitedHealthcare Insurance Company issued 181% more adverse decisions than in FY 2022.

2. In FY 2023, the carriers administratively reversed only 404 of the reported adverse decisions; less than 1%.

3. In FY 2023, consumers filed 10,884 grievances, challenging only 8% of the adverse decisions.

4. As with FY 2022, the largest percentage of grievances filed were in the pharmacy (48%), dental (25%), lab/radiology (13%), and physician (6%) service categories.

5. Overall, in FY 2023, during the internal grievance process, carriers overturned or modified 53% of their original adverse decisions.

6. Adverse decisions involving mental health/substance abuse services continue to be overturned or modified infrequently. In FY 2023, carriers reported an overturned or modified rate of 37% for mental health and substance abuse services.

7. In FY 2023, 50% or more of the pharmacy (64%), inpatient hospitalization (60%), and home health (67%) decisions were overturned or modified.

8. In FY 2023, dental decisions were overturned or modified 45% of the time.

As noted above, because carriers do not report clean claims data, it is unknown whether these year-over-year increases are proportional to an increased number of total claims; whether increases are a result of other issues in a particular category or categories; or whether there is an ongoing trend in either the specific or aggregate data. These unknowns stress again the importance of requiring carriers to fully report on claims.

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 the insurance carrier's internal grievance process has been fully exhausted, 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 to request 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 (except emergency issues must be resolved within 24 hours), 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 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 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

[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.

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 the MIA to 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 2023

MIA-provided data are reported on the charts and tables contained on pages 24-30 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 775 complaints in FY 2023. After reviewing these complaints, the MIA determined that 342 involved MIA-regulated adverse decisions.

2. The MIA referred 38 of those complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 304 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 209 cases (69%). The MIA upheld 95 (31%) of the carrier's initial decisions.

4. Like FY 2022, the largest percentages of grievances filed involved pharmacy services/formulary issues (43%); lab, imaging, and test services (25%); dental care (12%); and physician services (10%).

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 understand 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 to 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 who encountered 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 the 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 2023

The HEAU Appeals and Grievances data[11] are reported in the charts and tables contained on pages 32-47 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 2023.

The HEAU closed 2,037 cases in FY 2023.

[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.

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. 11% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection-related issues.

3. 763 of the complaints closed by the HEAU were cases involving appeals and grievances. Not all the 763 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 763 appeals and grievances cases the HEAU closed during FY 2023, 504 (66%) involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 504 cases involved more than one carrier.

4. Of the 504 appeals and grievances cases the HEAU mediated during FY 2023, 27% were adverse decision (*medical necessity*) cases, 52% were coverage decision (*contractual exclusion*) cases, and 21% were eligibility cases.

5. The HEAU mediation process resulted in 56% of the medical necessity cases, 56% of the coverage decision cases, and 60% of the eligibility denial cases being overturned or modified.

6. HEAU mediation efforts resulted in a decision change in 60% 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 54% of the time.

7. In FY 2023, the HEAU assisted patients in recovering or saving over $3.3 million dollars, including over $2.6 million in appeals and grievances cases.

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, 57% 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 53-year-old woman was referred to a neurologist after experiencing a transient ischemic attack (TIA or "mini-stroke"). She also had a history of complex migraines. She had tried various medications for treatment of her migraines with no improvement, and in one instance experienced a severe reaction. The neurologist provided her with a branded medication with no generic available (physician samples) and the patient experienced significant improvement. However, when the neurologist tried to get the medication pre-authorized for maintenance, it was denied by the patient's plan's Pharmacy Benefit Manager ("PBM") for not meeting Step Therapy protocols. The HEAU successfully appealed to the PBM for an exception because step therapies had already been tried and failed. The PBM overturned the denial and authorized coverage of the prescription, saving the patient $980/per month in out-of-pocket costs. It took nearly five months from the time the provider initially prescribed the medication until it was approved.

2. A claim for a Positron Emission Tomography (PET) scan for a 16-year-old girl with epithelioid hemangioendothelioma (EHE), a rare type of vascular cancer that affects the lining of the blood vessels, was denied by the carrier as not "medically necessary." She had also recently been diagnosed with uveitis (a form of eye inflammation), another rare condition, and her medical team was unsure whether a link existed to her EHE. A previous PET scan had shown active lymph nodes, and the subsequent scan was sought to guide future biopsies and to determine if the uveitis was a result of active EHE or another malignancy, essential to determining her treatment plan. The carrier denied reimbursement in the first instance and during the internal appeal process, but when the HEAU submitted a second-level internal appeal, the denial was overturned.

3. A five-year-old child born with multiple, complex, and ongoing medical needs, had been receiving carrier-covered home nursing care since birth in 2017. On very short notice, the carrier reduced the number of covered hours of home nursing care for the child citing a lack of medical necessity for the eliminated hours, despite no change in the child's conditions or care needs. The HEAU submitted an urgent internal appeal to the carrier and the denial was upheld. The HEAU then made an urgent appeal to the MIA for external review. Within four days, the carrier reversed its denial and retroactively authorized the services, reimbursing the family over $18,000 for the previously denied hours.

4. The HEAU secured a $4,000 refund from an assisted living facility for the surviving spouse after her husband died two days after admission to the facility. They had prepaid $6,709 to the facility in October 2021. The facility ignored the wife's inquiries, but after 15 months of advocacy by the HEAU, the facility finally refunded the patient's widow.

5. A consumer wrote to the HEAU because his health insurance would not authorize an MRI on his lower back. His provider needed the MRI to determine whether surgery, pain management, or some other intervention would be the best course of treatment. The consumer was in excruciating pain but as a recovering drug addict he was

committed to getting through each day without falling back into the abyss of drugs. He was frequently in tears of pain and frustration. The carrier insisted a long list of requirements had to be met before the MRI could be approved. The HEAU was able to compile enough information and records to convince the carrier to approve the MRI during the internal appeal process.

6. The HEAU has handled ongoing mental health access issues for a family with a 16-year-old autistic son. The carrier has no in-network providers available to provide the child with all necessary services and was unwilling to approve telehealth services. Instead of providing the needed care, the insurer attempted to reduce needed services. The insurer also initially denied a single case agreement (SCA) with an out-of-network provider without considering the child's unique needs. After HEAU intervention, the insurer entered an SCA with an out-of-network provider (for six months) and restored telehealth services. Although this arrangement is providing needed care, the insurer has not yet agreed to a longer-term means of meeting the child's needs.

7. The family of a child with gender dysphoria, unable to locate an in-network provider with experience in psychotherapy for children with gender dysphoria, sought a single case agreement (SCA) with an out-of-network provider that was denied by the carrier. After the HEAU appealed, the carrier reprocessed the claims for services and retroactively approved an SCA and approved the agreement for future coverage as in-network for an additional year.

8. The HEAU filed an external appeal of two prior adverse decisions denying continuing inpatient services for a patient who was hospitalized for suicidal ideation, delusion disorder, and depression. After a month of inpatient care, the patient's medically necessary level of care was reduced by the provider to a partial hospitalization program (PHP), but no PHP spot was available due to COVID pandemic-related delivery disruptions. The patient remained in the hospital an additional 10 days until the hospital team deemed it safe to discharge her home to await an available PHP placement. The carrier denied coverage for this period as not medically necessary, but the HEAU argued that because the lower level of care was unavailable, continued inpatient care was medically necessary as it was the only treatment option available at the time. Ultimately the HEAU sought an external appeal. After reviewing over 1,000 pages of provider records, the external reviewer agreed, and the denial was overturned.

9. A federal employee contacted the HEAU for assistance with a "No Surprises Act" billing and coverage dispute because her carrier imposed out-of-network cost-sharing for emergency care. The consumer, who was in acute mental distress, was taken by a family member to the emergency room of her local hospital, which was in-network. It was determined that the consumer needed to be admitted as an inpatient and she was transported by ambulance down the street to the local hospital's new stand-alone out-of-network mental health facility for inpatient admission. Rather than imposing a 15% in-network cost-sharing responsibility as required by the No Surprises Act for emergency services, the carrier applied out-of-network cost sharing of 35%. The carrier

upheld its original decision during the internal appeal process. After the HEAU contacted the US Office of Personnel Management the consumer received the reduced 15% cost-sharing balance.

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 should be considered, especially when the denial presents inherent health or safety risks to a patient. *See*, How Cigna Saves Millions by Having its Doctors Reject Claims Without Reading Them, *March 25, 2023,* https://www.fiercehealthcare.com/payers/noticing-prior-authorization-surge-democrats-demand-better-ai-oversight, and Amid Concerns about claims denials, Democrats seek greater oversight of Medicare Advantage plans' use of AI, November 3, 2023, https://www.fiercehealthcare.com/payers/noticing-prior-authorization-surge-democrats-demand-better-ai-oversight.

C. Additional HEAU Activities and Data

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

In FY 2023, categories in which the HEAU received the largest number of non-appeals-related cases were:

- Quality of Care - Consumer Displeased with Quality of Care
- Billing - Patient Feels that Charges are Too High
- Billing - Billed for Services Not Performed
- Billing - Consumer Seeks Itemized Bill or Clarification of Charges
- Assistance Request - Consumer Requesting Information or Response to Question
- Billing - Failure to Refund Overpayment
- Providing Misleading Information
- Enrollment - APTC/CSR Dispute
- Medical Records - Patient Requesting Copies of Medical Records
- Billing - Billing for Charges Already Paid

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 Nursing Home Acquisitions Workgroups; the Health Insurance Utilization Review Workgroup, and the Health Services Cost Review Commission's Hospital Payment Plan Guideline and Medical Bill Reimbursement Process Workgroups.

The HEAU also provided consultative and litigation support to the Office of the Attorney General in its efforts to advance and defend the consumer protections afforded to Marylanders by the Affordable Care Act and other federal laws and 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. Hospital Financial Assistance Policies - Geographic Limitation

The HEAU is aware of several hospital systems that limit financial assistance to defined service areas including specific zip codes. See MedStar Financial Assistance Information by Zip Code. https://www.medstarhealth.org/financial-assistance-policy.

The HEAU has been advised that hospitals believe they have the authority to limit financial assistance to certain geographic areas because of the "mission and service area" language in Md. Code Ann., Health Gen. § 19-214.1(b)(2)(ii) and (iii). We are still evaluating how hospitals are applying this limitation but believe the mission and service area language was added as a factor that hospitals and the HSCRC could consider when determining the FPL thresholds for reduced cost care, not as a barrier to reduced cost care or other debt relief provisions.

MedStar's zip code definition is inconsistent with the remedial intent of the financial assistance protections as evidenced by a recent complaint the HEAU handled for a consumer who presented to MedStar Washington Hospital in distress. She described being new to the area and googling a local emergency room and that MedStar, which was 5.5 miles from her home came up as the first option. She was denied financial assistance by MedStar because her home was not within MedStar's "defined service area." Though making a "one time exception" for the consumer and noting that "future exceptions may not be approved," MedStar posited to the HEAU that the closer option for her, Luminis Health Doctors Community Medical Center, was 5.4 miles from her home.

The HEAU recommends clarifying language.

2. Hospital Facility Fees

During the 2019 and 2020 sessions, the HEAU sought legislation to address the growing prevalence of hospital outpatient facility fees and the financial harms consumers suffered due to these surprise charges. Ultimately, the Facility Fee Right to Know Act was passed, requiring that consumers be given specific statutorily proscribed notice of a small subsection of the outpatient fees. Md. Code Ann., Health Gen. § 19-349.2. The HEAU advocated for notice for all outpatient facility fees but in a last-minute amendment, hospitals sought and obtained a significant limitation, requiring that statutory notice be provided only to consumers scheduled for "clinic services" that aren't otherwise billed in another rate center. This limiting language means that consumers continue to be blindsided by surprise facility fees when they obtain the following types of services:

a. Diagnostic Radiology, Ultrasound, and Vascular
b. Nuclear Medicine
c. Radiology Therapeutic
d. Electrocardiography
e. Electroencephalography
f. Physical Therapy & Occupational Therapy

g. Respiratory Therapy & Pulmonary Function Testing
h. Leukopheresis
i. Labor and Delivery
j. Interventional Radiology/Cardiovascular
k. Ambulance Services – Rebundled
l. Speech Therapy
m. Audiology
n. Laboratory Services
o. CT/MRI

At the time, Maryland was one of only a few states to address these burgeoning fees, but state and federal lawmakers and consumer advocacy groups across the country are pursuing reforms to reduce the surprise and the consumer and employer health care costs associated with facility fees. Georgetown University's Center on Health Insurance Reforms recently published a report, *Regulating Outpatient Facility Fees: States are Leading the Way to Protect Consumers*, July 2023, exploring why and how many states are taking on the regulation of these fees.

The HEAU recommends further evaluation of this issue by the General Assembly and suggests that a workgroup be convened to research and issue a report by next year on the impact of facility fees on Maryland's health care system. In the interim, the HEAU recommends legislation prohibiting facility fees for clinic services not otherwise billed in another rate center, and that the current statutory notice be required for facility fees billed in the rate centers outlined above.

3. Other Out-of-Network Facilities

The HEAU has received an increasing number of complaints from consumers who are referred by an in-network provider to an out-of-network facility for services. Consumers are referred to facilities without realizing that they are out-of-network and have incurred bills much higher than they would have incurred at an in-network facility. Some facilities provide no out-of-network notice, others have consumers sign forms that say the facility might be out-of-network. But consumers sign many forms when they present for services without having the opportunity to carefully read them or having the opportunity to edit them in any way. Requiring pre-appointment, stand-alone notice, with cost estimates, should help alleviate the surprise and provide the consumers with the material price information they are entitled to.

4. Ongoing Concerns

The HEAU remains concerned about providers requiring pre-treatment payments of deductibles and coinsurance, hospital and medical providers' 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 and 2022 reports. The HEAU also continues to experience an increased scope of work despite the loss of case workers, which creates challenges in providing needed assistance to consumers.

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

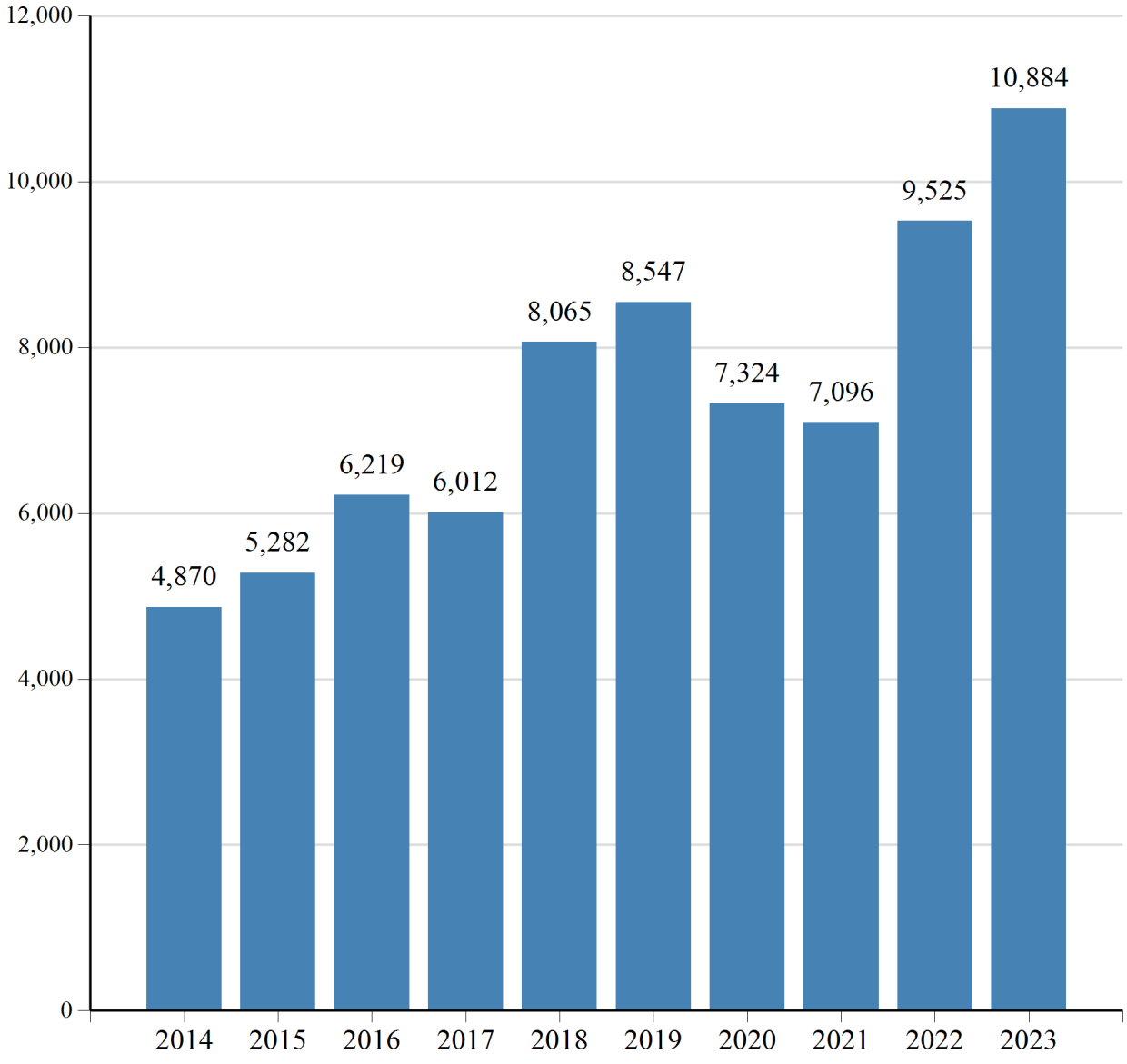
Carrier Cases
Adverse Decisions, Grievances and Outcomes

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Aetna Dental Inc.	653	0	0	0%	0%
Aetna Health Inc. (a Pennsylvania corporation)	134	12	217	46%	54%
Aetna Life Insurance Company	298	18	236	57%	43%
Alpha Dental Programs, Inc.	12	0	100	64%	36%
Ameritas Life Insurance Corp.	414	0	265	56%	44%
CareFirst BlueChoice, Inc.	28,389	0	2,849	44%	56%
Carefirst of Maryland, Inc.	10,364	0	1,070	37%	63%
Chesapeake Life Insurance Company	0	0	1	100%	0%
CIGNA Dental Health of Maryland, Inc.	29	0	1	100%	0%
CIGNA Health and Life Insurance Company	16,934	43	668	50%	50%
Connecticut General Life Insurance Company	2	0	0	0%	0%
Delta Dental Insurance Company	7	0	36	72%	28%
Delta Dental of Pennsylvania	53	0	311	68%	32%
Dental Network, Inc.	8	1	0	0%	0%
Dentegra Insurance Company	0	0	37	68%	32%
Dominion Dental Services, Inc.	2,473	0	254	61%	39%
Golden Rule Insurance Company	6	0	6	67%	33%
Group Dental Service of Maryland, Inc.	3	0	0	0%	0%
Group Hospitalization and Medical Services, Inc.	8,076	0	1,018	42%	58%
Guardian Life Insurance Company of America	1,310	201	760	56%	44%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Johns Hopkins HealthCare LLC	54	0	27	41%	59%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	1,631	0	87	68%	32%
Kaiser Permanente Insurance Company	31	0	6	83%	17%
Lincoln National Life Insurance Company, The	89	24	0	0%	0%
MAMSI Life and Health Insurance Company	6,666	0	105	50%	50%
Metropolitan Life Insurance Company	612	90	31	35%	65%
Optimum Choice, Inc.	8,436	0	740	55%	45%
Principal Life Insurance Company	811	0	26	73%	27%
Prudential Insurance Company of America	0	0	1	0%	100%
Reliance Standard Life Insurance Company	20	0	6	100%	0%
Standard Insurance Company	214	0	51	49%	51%
Starmount Life Insurance Company	4	0	8	75%	25%
Sun Life Assurance Company of Canada	530	0	40	73%	28%
United Concordia Insurance Company	607	0	290	43%	57%
United of Omaha Life Insurance Company	354	15	0	0%	0%
UnitedHealthcare Insurance Company	43,889	0	1,549	40%	60%
UnitedHealthcare of the Mid-Atlantic, Inc.	2,603	0	54	54%	46%
Wellfleet Group LLC	184	0	32	53%	47%
Wellfleet Insurance Company	22	0	2	50%	50%
Totals	**135,922**	**404**	**10,884**	**47%**	**53%**

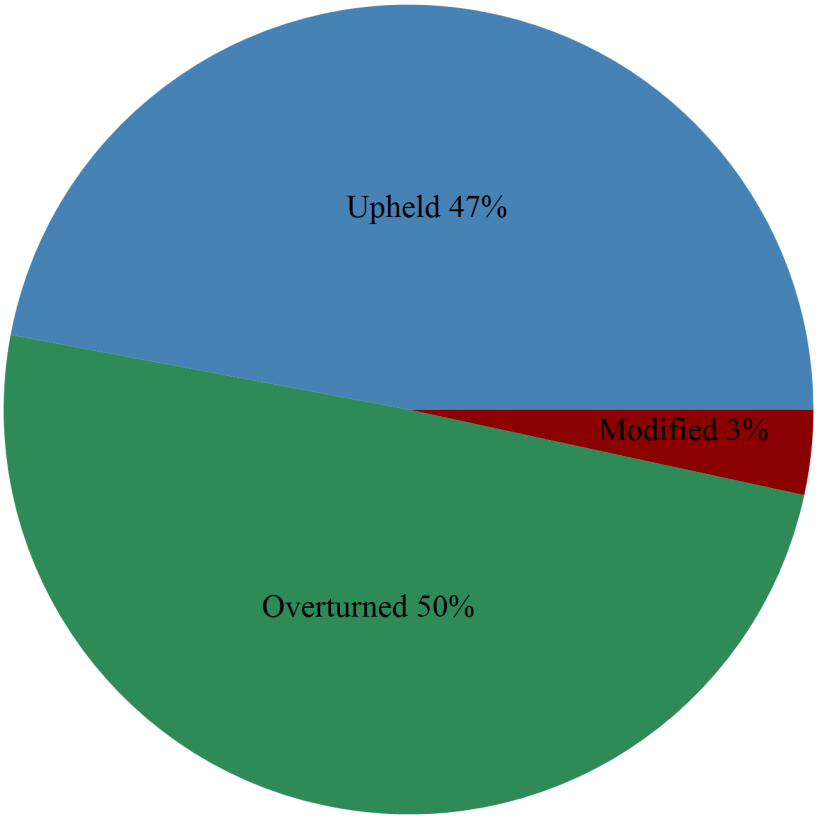
Carrier Grievances Cases
Number of Grievances Over 10 Fiscal Years

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.



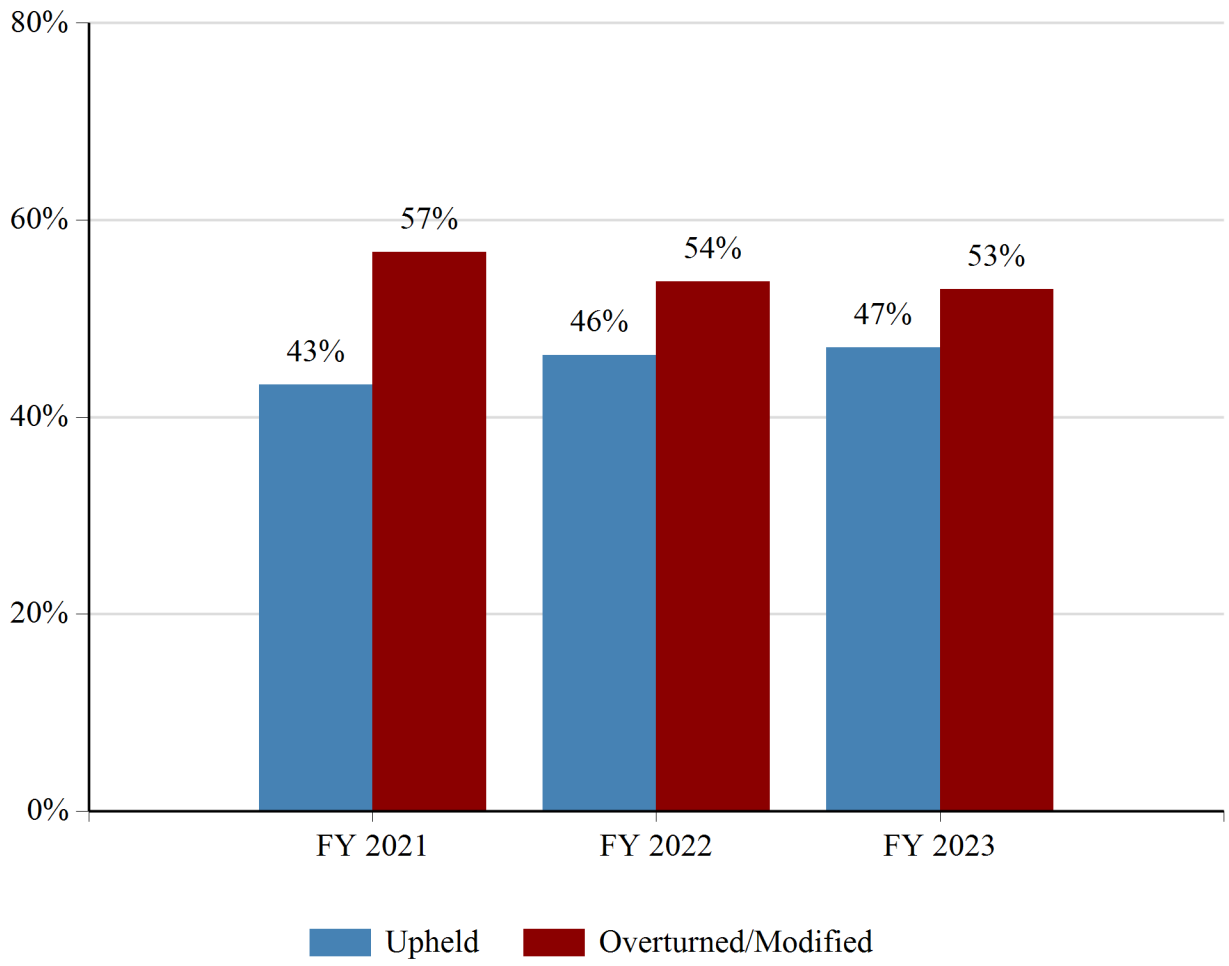
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 10,884 internal grievances filed with carriers in FY 2023, as reported by the carriers.



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 2023, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	14,764	10.862%	2,674	24.568%
Durable Medical Equipment	1,474	1.084%	242	2.223%
Emergency Room	191	0.141%	30	0.276%
Home Health	117	0.086%	6	0.055%
Inpatient Hospital	1,456	1.071%	114	1.047%
Laboratory, Radiology	27,550	20.269%	1,390	12.771%
Mental Health / Substance Abuse	753	0.554%	65	0.597%
Other*	2,677	1.970%	464	4.263%
Pharmacy	57,881	42.584%	5,188	47.666%
Physician	25,264	18.587%	643	5.908%
PT, OT, ST, including inpatient rehabilitation	3,682	2.709%	53	0.487%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	113	0.083%	15	0.138%
Totals	**135,922**	**100%**	**10,884**	**100%**

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

Carrier Grievances Cases
Outcomes by Service Type

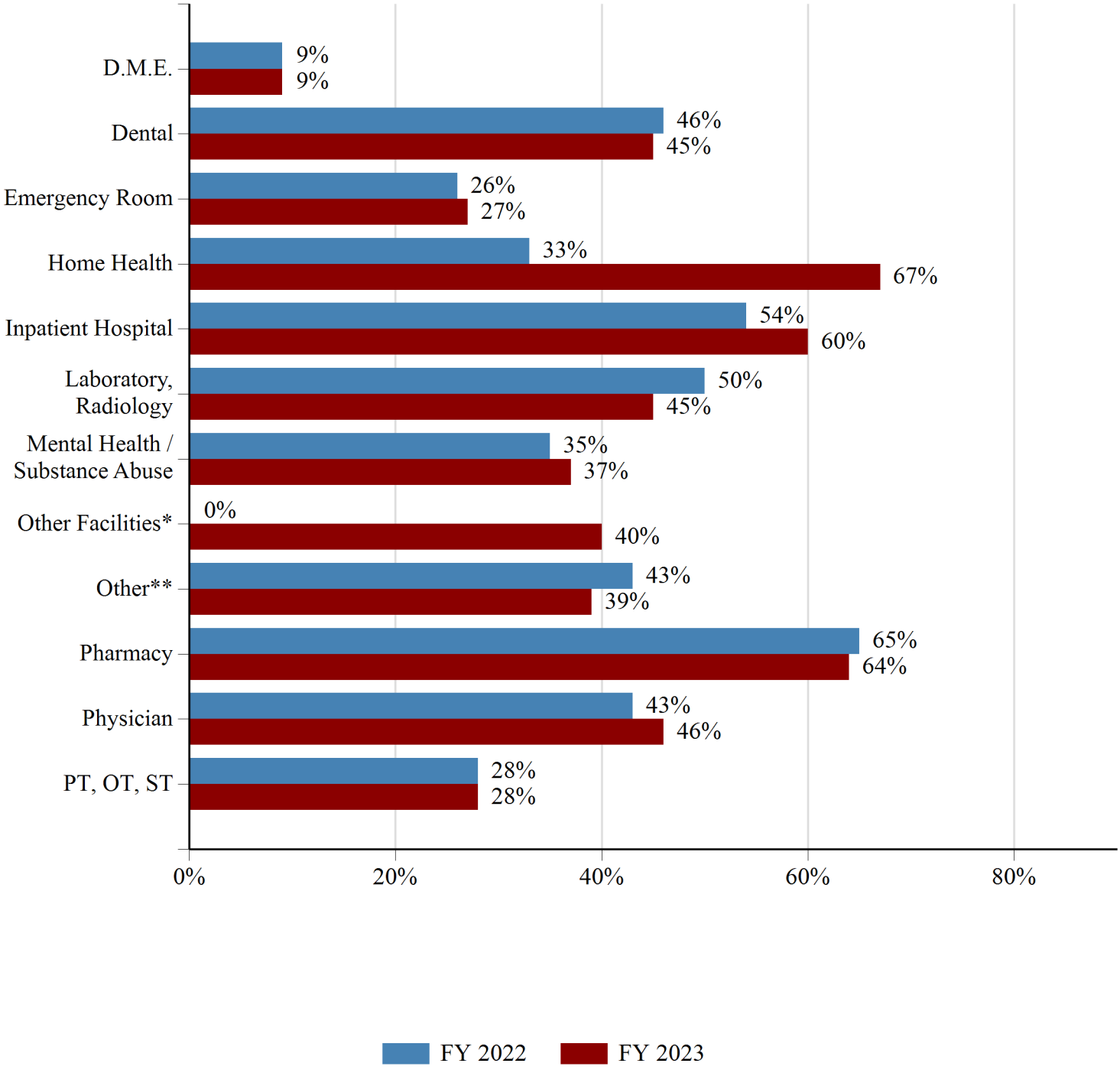
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Dental	2,674	55%	45%
Durable Medical Equipment	242	91%	9%
Emergency Room	30	73%	27%
Home Health	6	33%	67%
Inpatient Hospital	114	40%	60%
Laboratory, Radiology	1,390	55%	45%
Mental Health / Substance Abuse	65	63%	37%
Other*	464	61%	39%
Pharmacy	5,188	36%	64%
Physician	643	54%	46%
PT, OT, ST, including inpatient rehabilitation	53	72%	28%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	15	60%	40%
Totals	**10,884**	**47%**	**53%**

*"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 2022 and FY 2023.

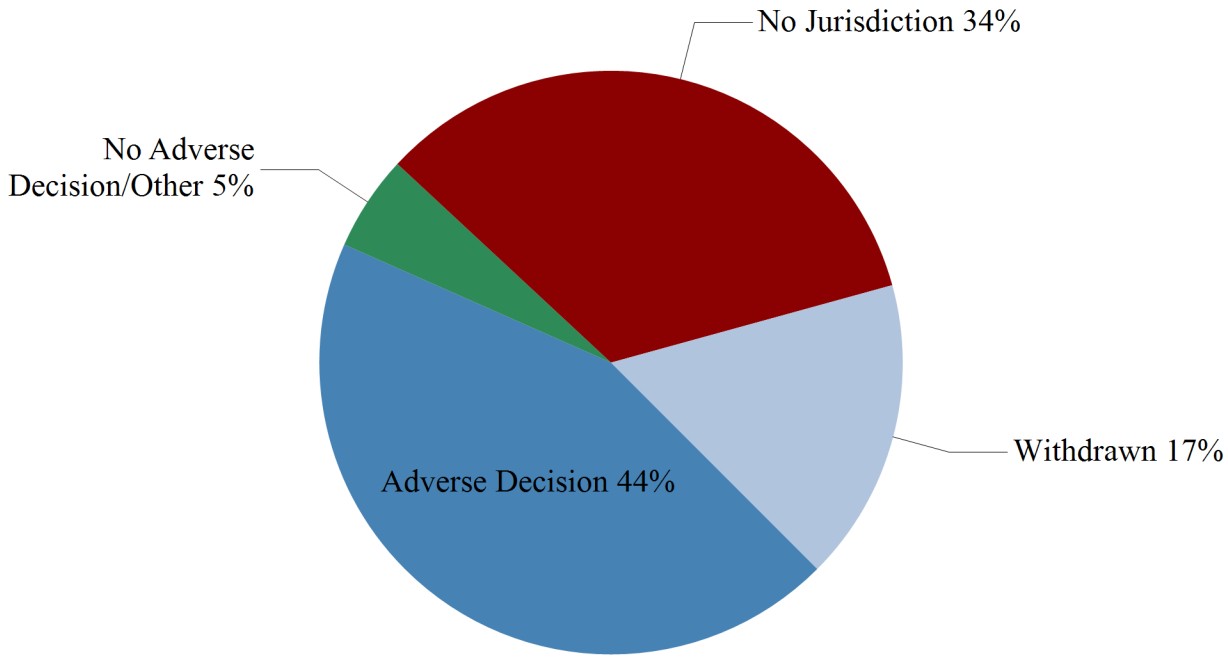


* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.
** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints
Initial Review of Cases

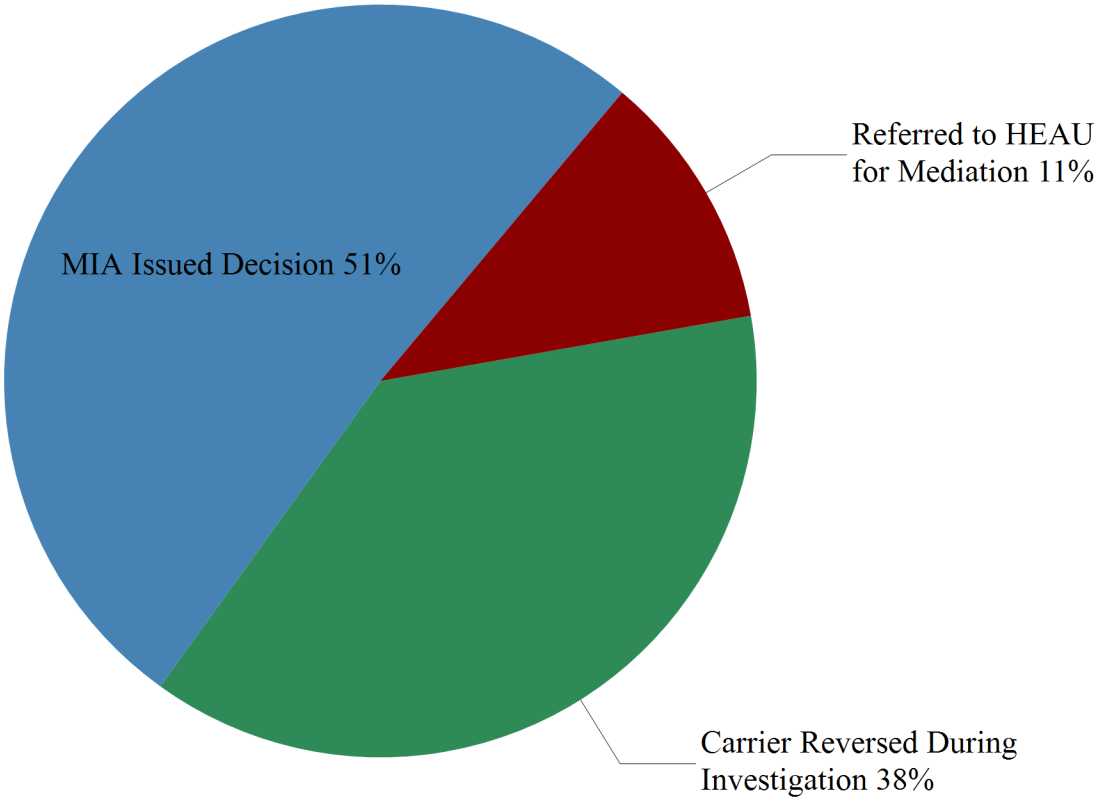
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some 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 775 cases filed with the MIA's Appeals and Grievances Unit during FY 2023.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2023, the MIA determined that 342 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 38 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 342 grievances the MIA reviewed during FY 2023.



MIA Appeals and Grievances Cases
Carriers and Disposition

The table below details the outcomes of the 304 grievances complaints the MIA investigated during FY 2023. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

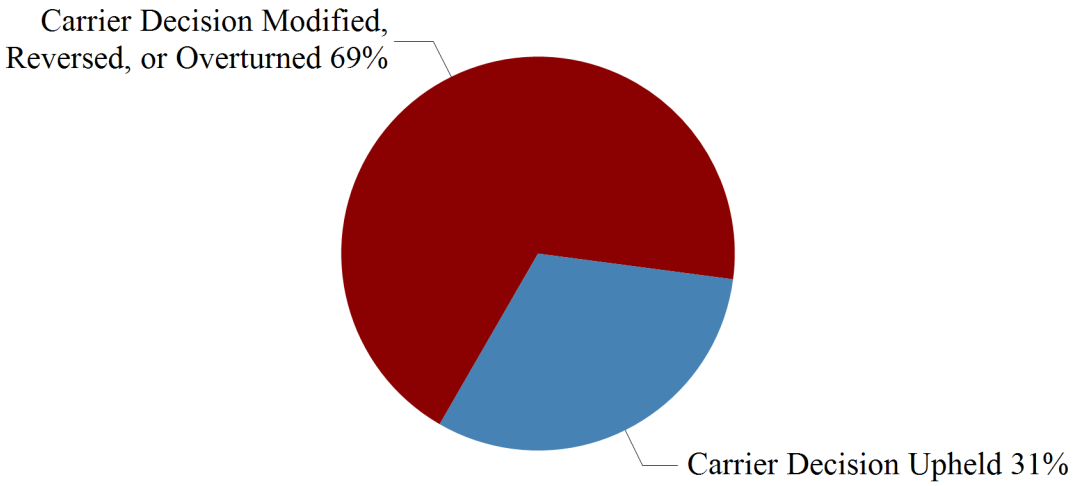
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Insurance Company	4	2	50.0%	0	0.0%	0	0.0%	2	50.0%
Aetna Life Insurance Company	8	2	25.0%	1	12.5%	1	12.5%	4	50.0%
Ameritas Life Insurance Corp.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
CareFirst BlueChoice, Inc.	95	33	34.7%	26	27.4%	0	0.0%	36	37.9%
Carefirst of Maryland, Inc.	69	17	24.6%	27	39.1%	0	0.0%	25	36.2%
CaremarkPCS Health L.L.C.	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
CIGNA Health and Life Insurance Company	15	6	40.0%	4	26.7%	0	0.0%	5	33.3%
Delta Dental Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Delta Dental of Pennsylvania	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Dominion Dental Services, Inc.	2	1	50.0%	1	50.0%	0	0.0%	0	0.0%
Express Scripts Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Group Hospitalization and Medical Services, Inc.	13	6	46.2%	2	15.4%	0	0.0%	5	38.5%
Guardian Life Insurance Company of America	12	5	41.7%	1	8.3%	0	0.0%	6	50.0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	6	2	33.3%	1	16.7%	0	0.0%	3	50.0%
Kaiser Permanente Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Optimum Choice, Inc.	8	2	25.0%	3	37.5%	0	0.0%	3	37.5%

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
United Concordia Dental Plans, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
United Concordia Insurance Company	2	2	100.0%	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Insurance Company	59	15	25.4%	11	18.6%	0	0.0%	33	55.9%
UnitedHealthcare of the Mid-Atlantic, Inc.	3	0	0.0%	1	33.3%	1	33.3%	1	33.3%
Totals	**304**	**95**	**31%**	**78**	**26%**	**2**	**1%**	**129**	**42%**

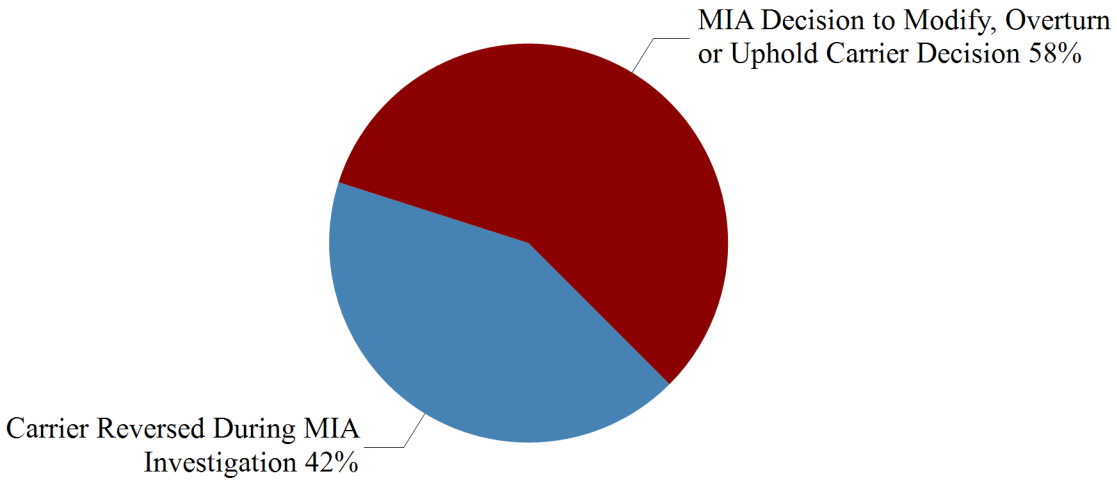
Percentages may not equal 100% due to rounding.

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 304 grievances the MIA investigated during FY 2023.

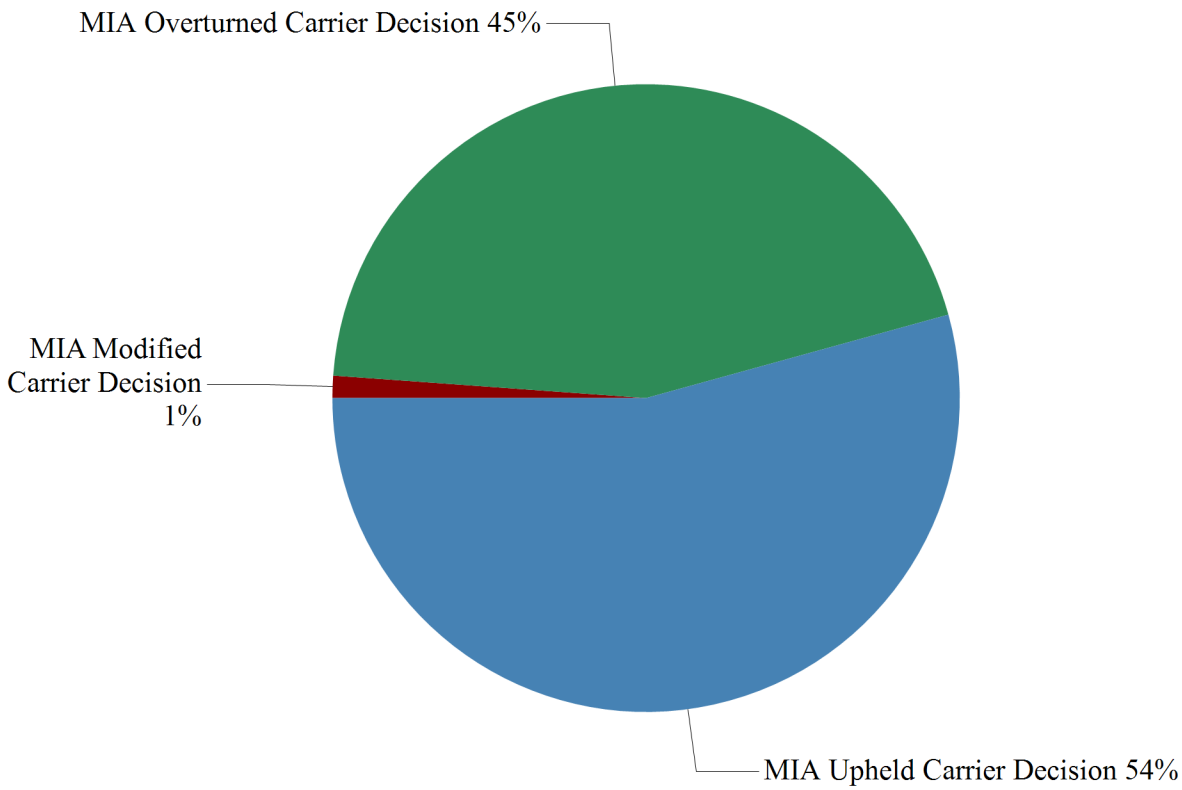


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 175 cases the MIA forwarded to an IRO for review in FY 2023.



MIA Appeals and Grievances Cases
Types of Services Denied and Outcomes

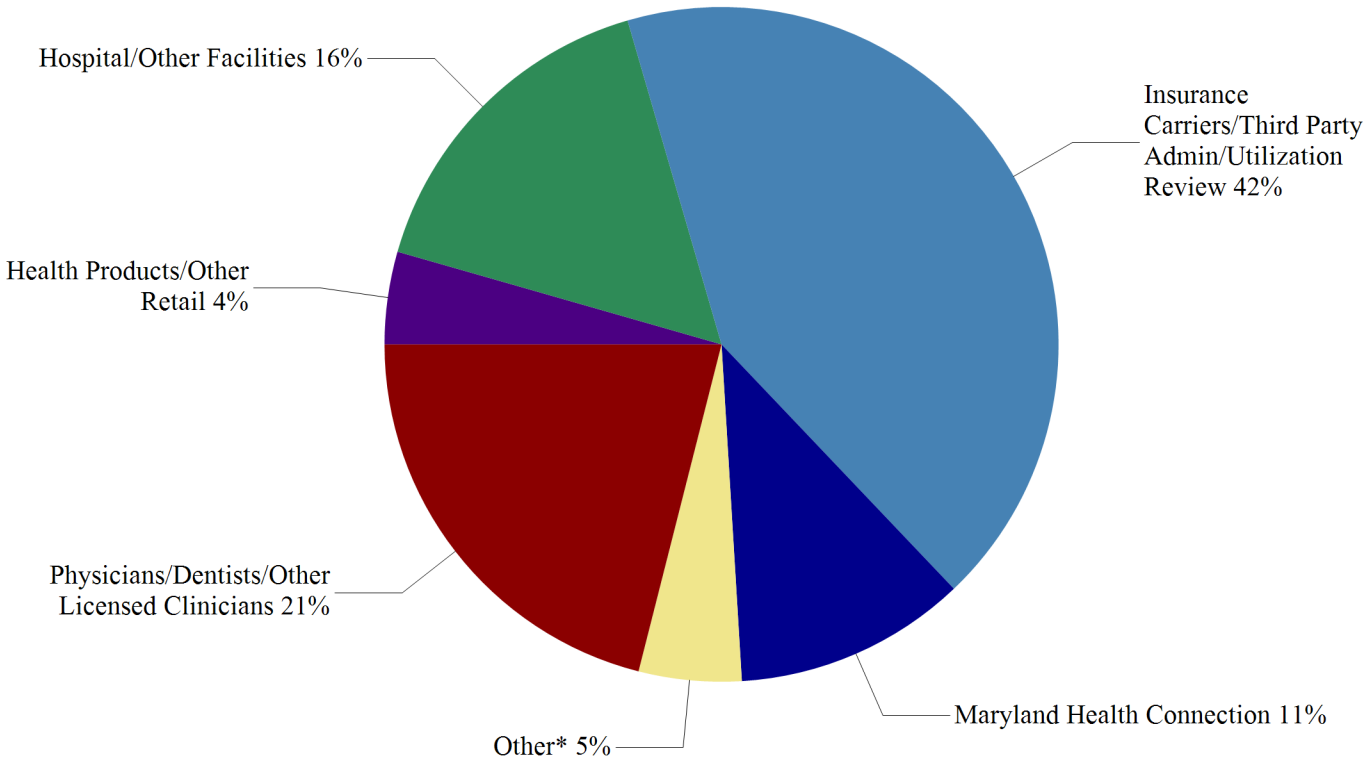
The table below identifies the types of services involved in grievances the MIA investigated during FY 2023. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Acupuncture	1	<1 %	0	0%	0	0%	0	0%	1	100%
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	35	12%	15	43%	3	9%	0	0%	17	49%
Durable Medical Equipment	7	2%	4	57%	1	14%	0	0%	2	29%
Emergency Services	1	<1 %	1	100%	0	0%	0	0%	0	0%
Experimental	10	3%	6	60%	3	30%	0	0%	1	10%
Home Care Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Hospitalization	1	<1 %	0	0%	0	0%	0	0%	1	100%
Lab, Imaging, Test Services	77	25%	31	40%	34	44%	1	1%	11	14%
Mental Health/Substance Abuse (Inpatient) Services	3	<1 %	2	67%	0	0%	0	0%	1	33%
Mental Health/Substance Abuse (Outpatient) Services	2	<1 %	0	0%	0	0%	0	0%	2	100%
Opioid Use Disorders	3	<1 %	0	0%	0	0%	0	0%	3	100%
Pharmacy Services/Formulary Issues	130	43%	25	19%	30	23%	0	0%	75	58%
Physician Services	29	10%	9	31%	6	21%	1	3%	13	45%
PT, OT, ST Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Totals	**304**	**100%**	**95**	**31%**	**78**	**26%**	**2**	**1%**	**129**	**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 2023. The HEAU closed 2,037 complaints. Some complaints were filed against more than one industry.

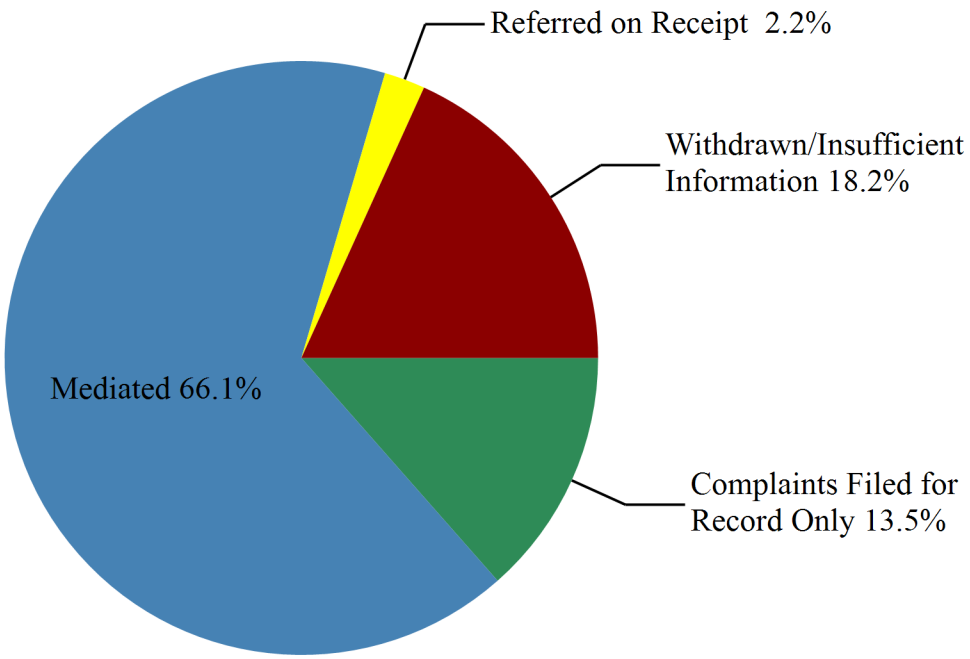


* "Other" includes Collection/Billing Entities, Ambulance, Government Agency, Employer, Online Marketing and other non-specific categories (e.g. HSA/FSA).

Percentages may not equal 100% due to rounding.

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 763 Appeals and Grievances cases closed by the HEAU during FY 2023.



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 2023. "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 504 cases in FY 2023. 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	1	1	100%	0	0%
Not State Regulated	51	21	41%	30	59%
Total Complaints	**52**	**22**	**42%**	**30**	**58%**
AIM Specialty Health					
State Regulated	6	2	33%	4	67%
Not State Regulated	2	2	100%	0	0%
Total Complaints	**8**	**4**	**50%**	**4**	**50%**
Allegiance					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Allied Benefit Systems, LLC					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
American Plan Administrators					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
American Specialty Health Group, Inc.					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Anthem Blue Cross and Blue Shield					
Not State Regulated	4	2	50%	2	50%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Anthem Blue Cross Blue Shield of Indiana					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Associated Administrators					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Bay Bridge Administrators, LLC					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield of Massachusetts					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
CareFirst					
State Regulated	126	53	42%	73	58%
Not State Regulated	62	31	50%	31	50%
Total Complaints	**188**	**84**	**45%**	**104**	**55%**
CareFirst Administrators					
Not State Regulated	12	6	50%	6	50%
Total Complaints	**12**	**6**	**50%**	**6**	**50%**
CareFirst the Dental Network					
State Regulated	4	0	0%	4	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**5**	**0**	**0%**	**5**	**100%**
CIGNA					
State Regulated	7	4	57.1%	3	42.9%
Not State Regulated	41	17	41%	24	59%
Total Complaints	**48**	**21**	**44%**	**27**	**56%**
Cigna Dental					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Conifer Health Solutions					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
CVS Caremark					
State Regulated	9	1	11%	8	89%
Not State Regulated	12	4	33%	8	67%
Total Complaints	**21**	**5**	**24%**	**16**	**76%**
Davis Vision					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Delta Dental					
State Regulated	6	3	50%	3	50%
Not State Regulated	4	2	50%	2	50%
Total Complaints	**10**	**5**	**50%**	**5**	**50%**
Dominion National					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
EviCore Healthcare					
State Regulated	2	2	100%	0	0%
Not State Regulated	4	2	50%	2	50%
Total Complaints	**6**	**4**	**67%**	**2**	**33%**
Express Scripts					
State Regulated	1	1	100%	0	0%
Not State Regulated	2	0	0%	2	100%
Total Complaints	**3**	**1**	**33%**	**2**	**67%**
First Health Network					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Golden Rule Insurance					
State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Government Employees Health Association (GEHA)					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Guardian Life Insurance Company of America					
State Regulated	7	3	43%	4	57%
Not State Regulated	3	2	67%	1	33%
Total Complaints	**10**	**5**	**50%**	**5**	**50%**
Highmark					
Not State Regulated	3	2	67%	1	33%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Humana					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Humana Dental, Inc.					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Humana Medicare Appeals					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Humana Military/Tricare					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Independence Blue Cross Blue Shield					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

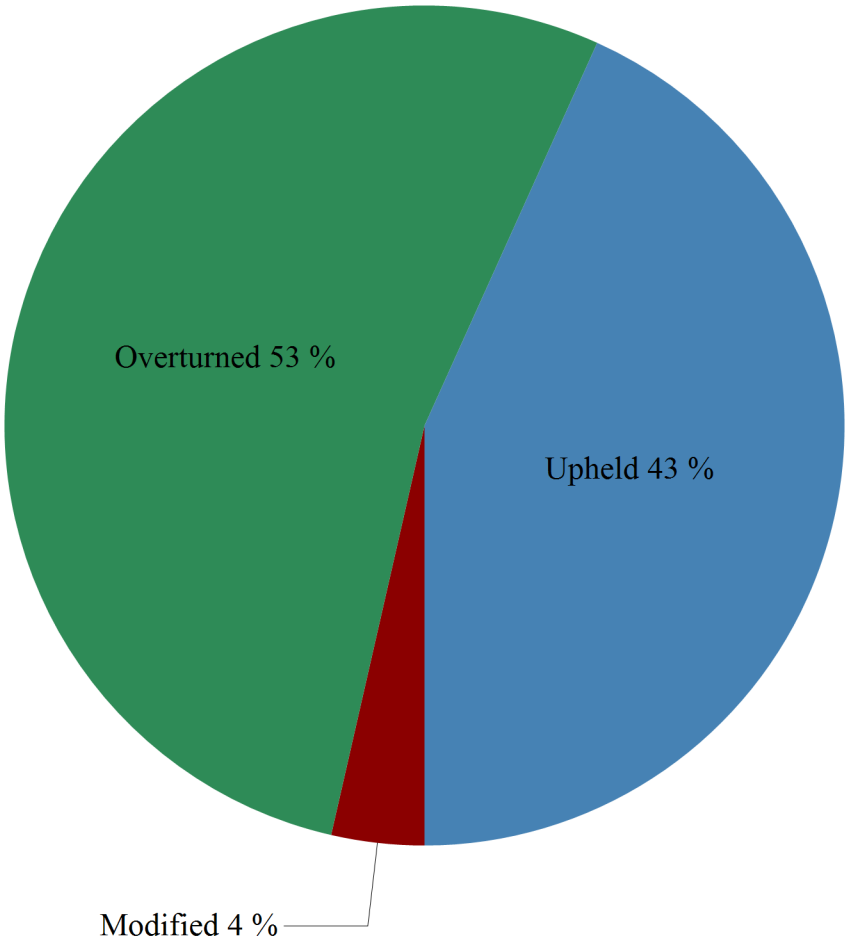
Carrier	Total Cases	Upheld		Overturned/Modified	
Johns Hopkins Advantage MD					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Johns Hopkins Employer Health Programs					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	34	11	32%	23	68%
Not State Regulated	4	2	50%	2	50%
Total Complaints	**38**	**13**	**34%**	**25**	**66%**
Maryland Health Connection					
State Regulated	6	2	33%	4	67%
Total Complaints	**6**	**2**	**33%**	**4**	**67%**
Medicare					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Merchants Benefit Administration, Inc.					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Meritain Health					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Metropolitan Life Insurance Company					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
National Claims Administrative Services					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
National Elevator Industry Health Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Nippon Life Benefits					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Optimum Choice					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Optum Rx					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Regence BlueCross BlueShield of Oregon					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Steamfitter's Local 602 Medical Fund					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Teamsters Local 639 Employers Health Trust					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
The Guardian Life Insurance Company of America					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Trustmark Insurance Company					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**

Carrier	Total Cases	Upheld		Overturned/Modified	
UMR					
Not State Regulated	5	3	60%	2	40%
Total Complaints	**5**	**3**	**60%**	**2**	**40%**
United Concordia Insurance Company					
State Regulated	1	1	100%	0	0%
Not State Regulated	5	4	80%	1	20%
Total Complaints	**6**	**5**	**83%**	**1**	**17%**
United of Omaha					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
UnitedHealthcare					
State Regulated	30	10	33%	20	67%
Not State Regulated	48	19	40%	29	60%
Total Complaints	**78**	**29**	**37%**	**49**	**63%**
WebTPA					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Wellfleet Insurance Company					
State Regulated	1	1	100%	0	0%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**

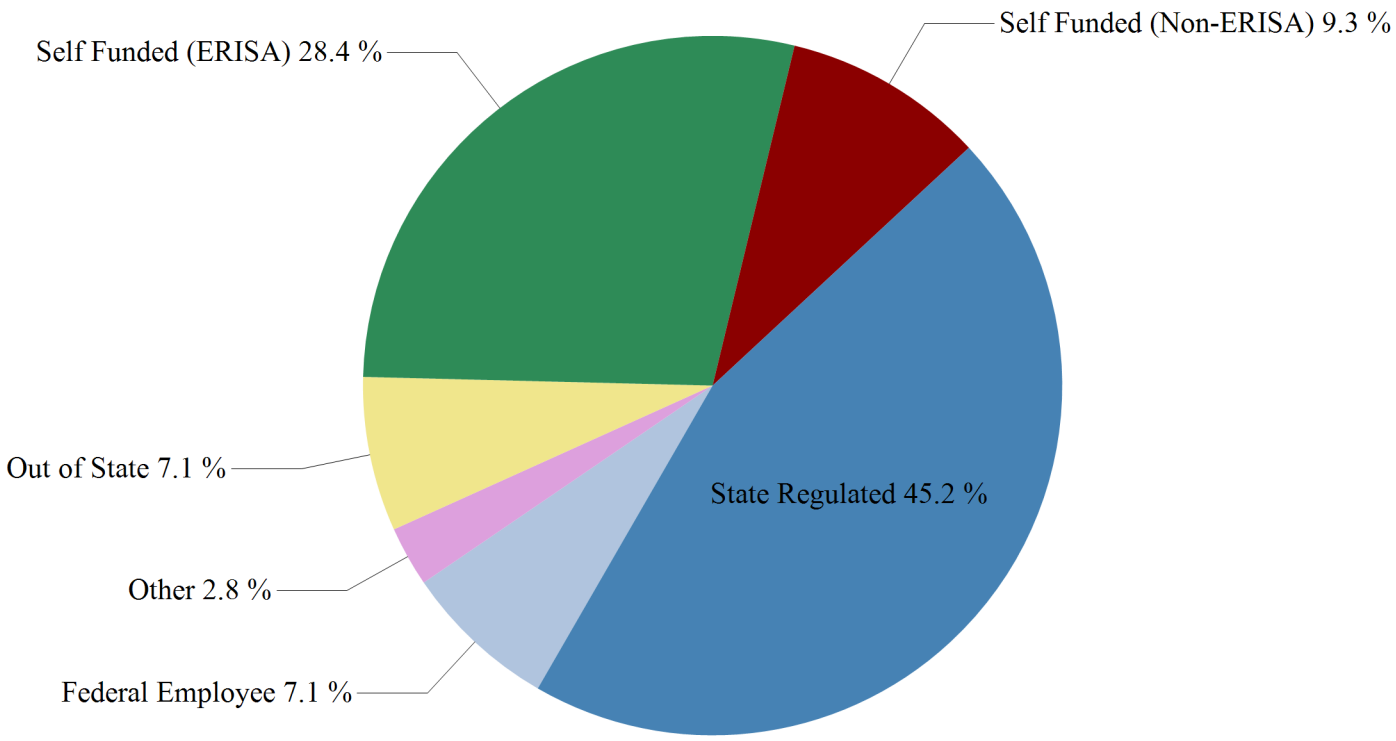
HEAU Mediated Appeals and Grievances Cases
Disposition

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 2023.



HEAU Mediated Appeals and Grievances Cases
Types of Carriers

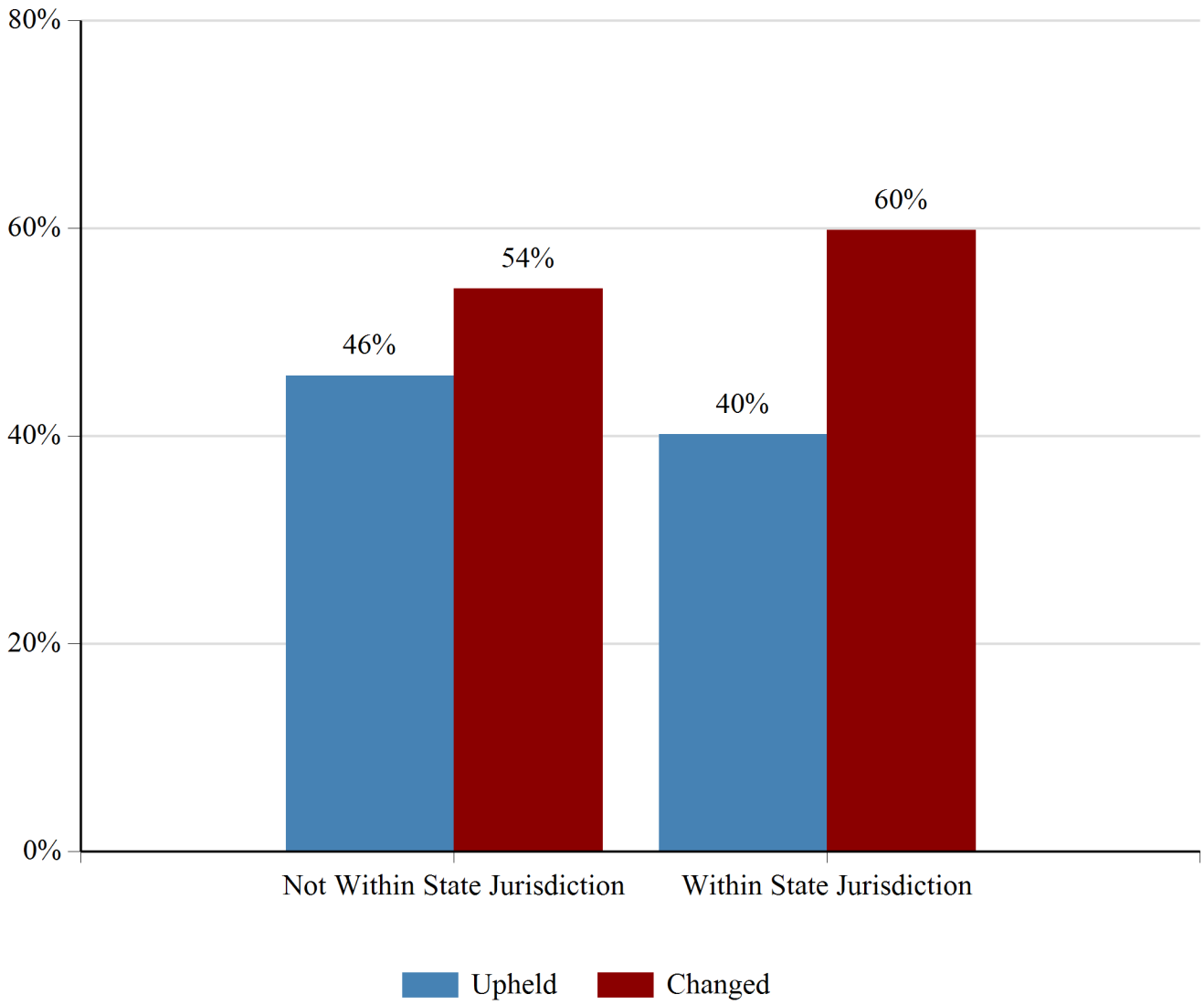
The chart below identifies the primary carrier types involved in the 504 Appeals and Grievances cases the HEAU mediated and closed during FY 2023.



Percentages may not equal 100% due to rounding.

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

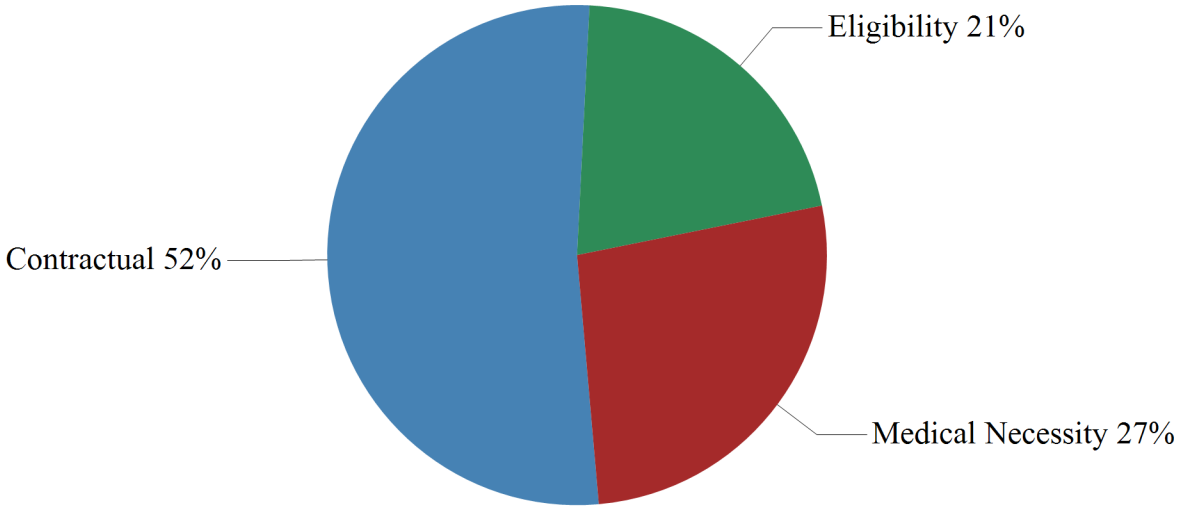
The chart below reflects the outcomes of the 504 Appeals and Grievances cases the HEAU mediated and closed during FY 2023 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

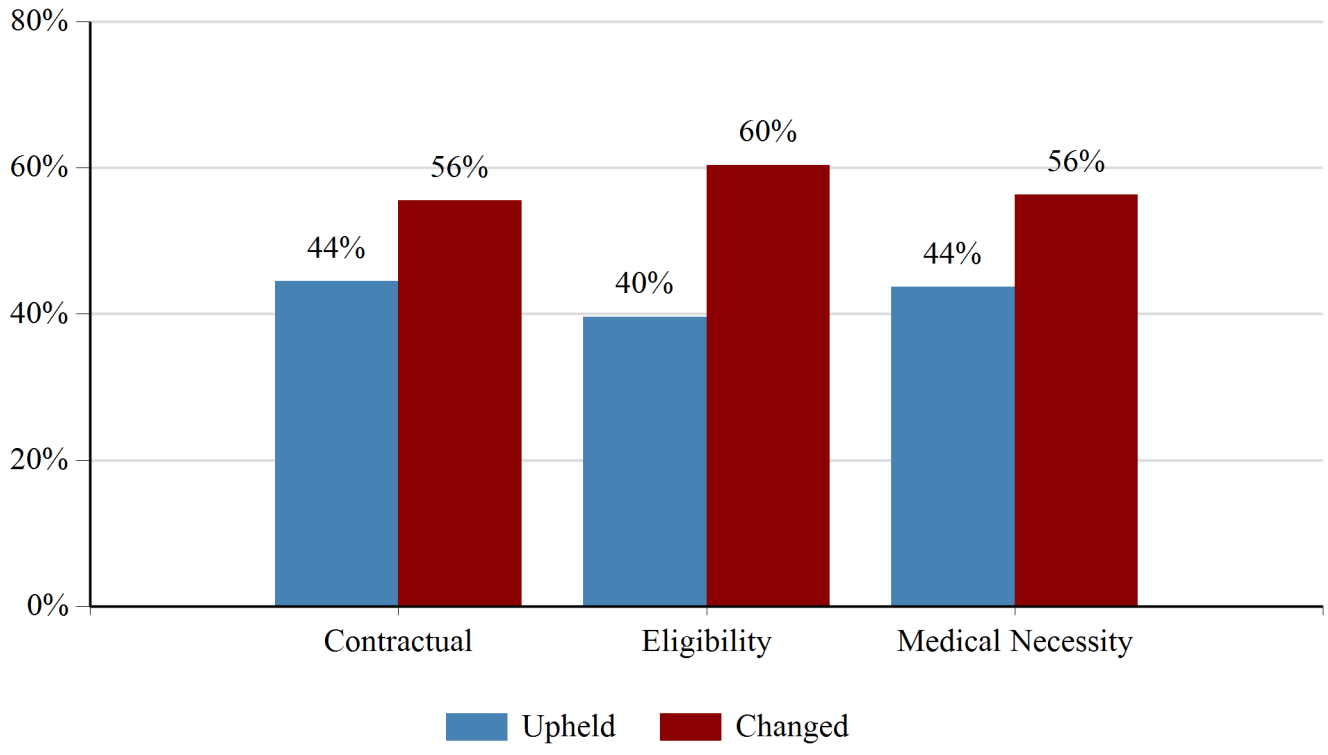
Types of Denials

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 2023.



Outcomes by Denial Type

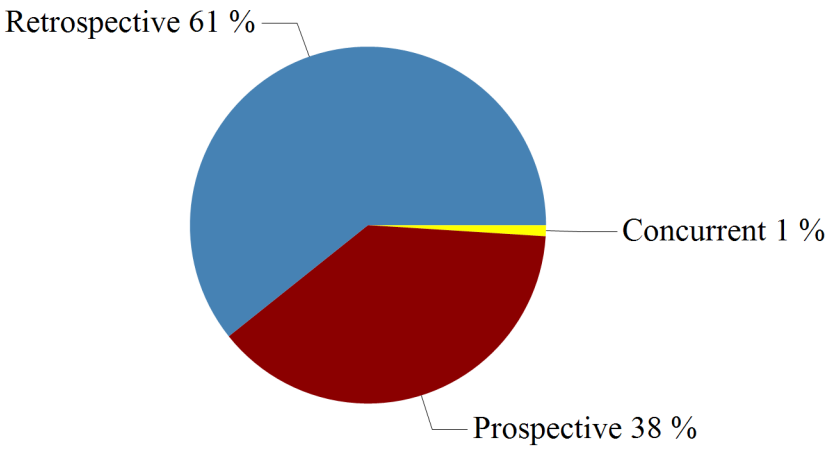
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2023.



HEAU Mediated Appeals and Grievances Cases

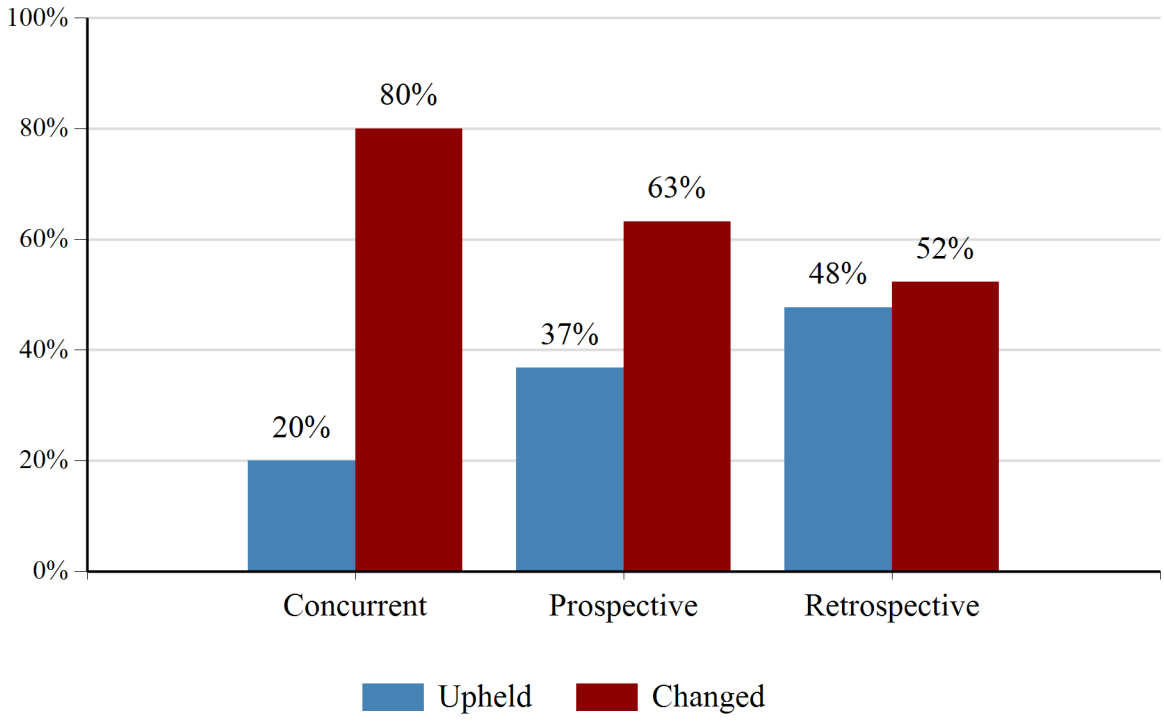
Timing of Denials

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 2023. Eligibility disputes are treated as prospective denials.



Outcomes by Timing of Denials

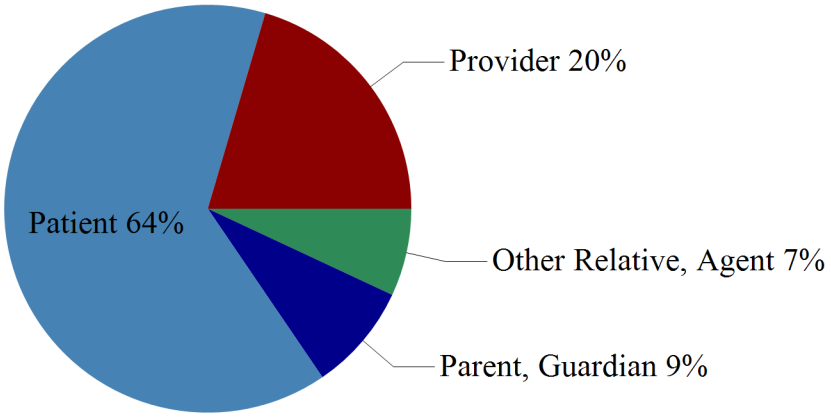
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2023 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

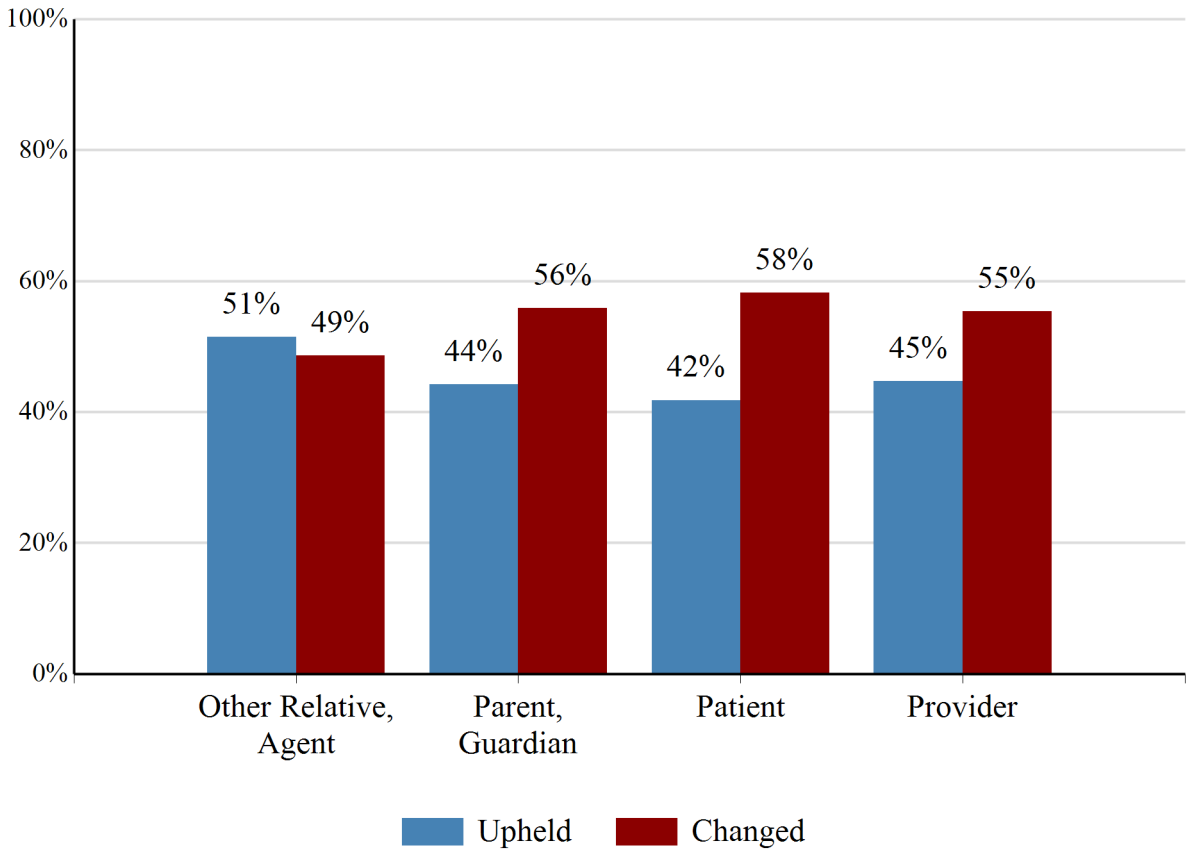
Who Filed the Case

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 2023.



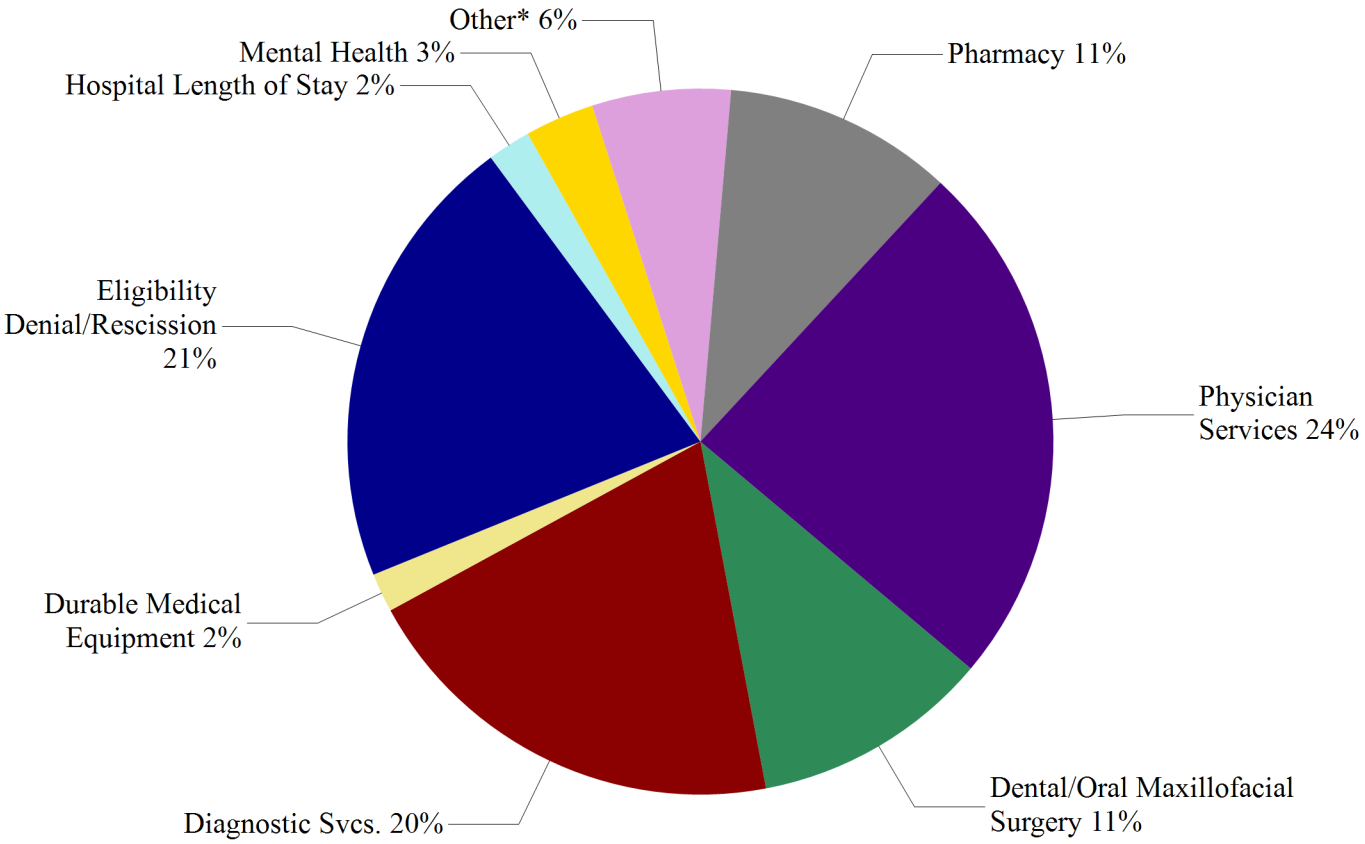
Outcomes by Who Filed the Case

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 2023.



HEAU Mediated Appeals and Grievances Cases
Types of Services Denied

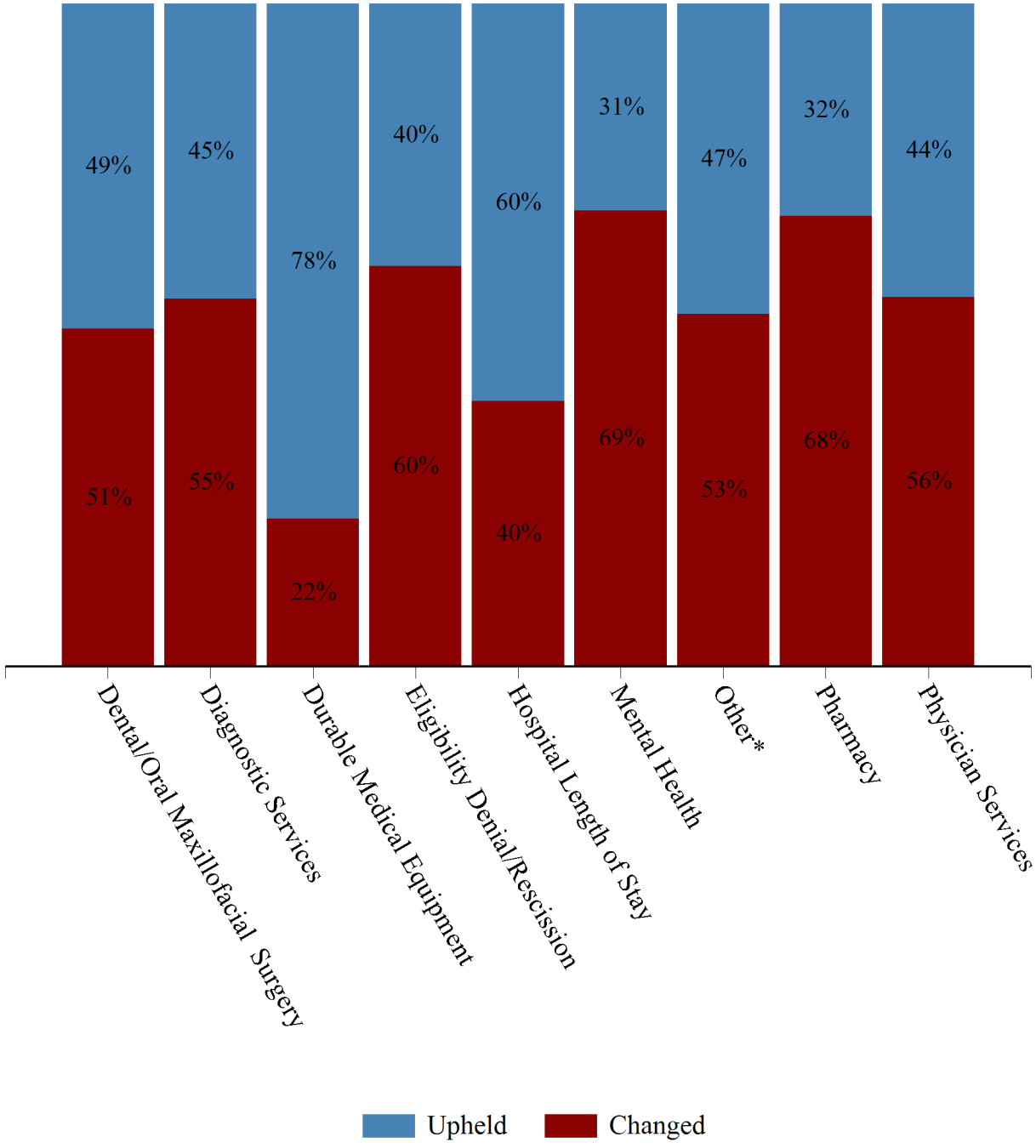
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2023.



* Other includes chiropractic, emergency room, home health, inpatient physical rehabilitation, optometry, physical, occupational, speech therapy - outpatient, podiatry, skilled nursing facility and transport.

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 2023 based on the types of services denied.



* Other includes chiropractic, emergency room, home health, inpatient physical rehabilitation, optometry, physical, occupational, speech therapy - outpatient, podiatry, skilled nursing facility and transport.