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 2019, beginning July 1, 2018 and concluding June 30, 2019.

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 a carrier's decision that someone is ineligible for coverage or a carrier's decision that results

[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.

in the rescission of an individual's coverage. As a result, since July 1, 2011, patients in Maryland 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, or the rescission of coverage.

As amended, Maryland law established 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[5] and July 2011[6], 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).

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

[5] 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 23, 2010).
[6] 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 26, 2011).

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[7] 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 did not extend external review rights for coverage decisions based strictly on contractual language unrelated to those decisions requiring medical judgment.

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 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.

[7] 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.

- 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 as carriers are not required to report membership or enrollee numbers.

Carrier Statistics FY 2019

In addition to the highlights below, charts providing statistical detail from the data submitted by the carriers appear on pages 16-24 of this report.

1. Carriers reported 75,204 adverse decisions in FY 2019, 911 fewer adverse decisions than reported in FY 2018. This decrease in the number of adverse decisions issued by carriers was the first decrease since FY 2013. Unfortunately, with the exception of Group Hospitalization and Medical Services, Inc., the carriers reporting the highest number of adverse decisions in FY 2018, increased the number of adverse decisions in FY 2019. In FY 2019, CareFirst BlueChoice, Inc. issued 6% more adverse decisions than in FY 2018; CareFirst of Maryland, Inc. issued 8% more adverse decisions than in FY 2018; CIGNA Health and Life Insurance Company issued 14% more adverse decisions than in FY 2018; and UnitedHealthcare Insurance Company issued 4% more adverse decisions than in FY 2018.

2. The carriers administratively reversed only 217 of the reported adverse decisions, less than 1%.

3. In FY 2019, consumers filed 8,547 grievances, a 6% increase over the 8,065 grievances filed in FY 2018.

4. The largest percentage of grievances filed were in the pharmacy (41%), dental (28%), lab/radiology (15%) and physician (7%) service categories.

5. Overall, in FY 2019, during the internal grievance process, carriers altered 54% of their original adverse decisions, overturning 49% of their adverse decisions and modifying 5%.

6. Adverse decisions involving mental health/substance abuse services continue to be overturned or modified infrequently. In FY 2019, carriers reported an overturned or modified rate of 34% for mental health and substance abuse services. This rate was higher than the 25% overturned or modified rate in FY 2018. Reversal rates in prior years include: 25% in FY 2017, 19% in FY 2016, 42% in FY 2015, 31% in FY 2014, 27% in FY 2013 and 23% in FY 2012.

7. In FY 2019, dental decisions were overturned 61% of the time. Adverse decisions involving pharmacy claims are also the most likely to be overturned as reflected in a

five year review of data: 59% in FY 2019, 60% in FY 2018, 65% in FY 2017, 71% in FY 2016, 62% in FY 2015, and 79% in FY 2014.

8. In FY 2019, inpatient hospital service decisions were overturned 66% of the time.

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 voluntarily elected to use the Maryland Insurance Administration's external review process to provide external review for their self-funded employee health benefit plans.[8]

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 5 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 7 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

[8] While the MIA only conducts the external review for individuals 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.

documentation, the case is copied and forwarded to an Independent Review Organization 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 the written determination via facsimile and first class 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, with the exception of 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 2019

MIA-provided data are reported on the charts and tables contained on pages 25-32 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 857 complaints in FY 2019. After reviewing these complaints, the MIA determined that 433 involved MIA-regulated adverse decisions.

2. The MIA referred 69 of those complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 364 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 course of the MIA's investigation in 243 cases (67%). The MIA upheld 121 (33%) of the carrier decisions.

4. Similar to FY 2018, the largest percentages of grievances filed were in the pharmacy (38%), dental care (22%), experimental (10%), and physician services (9%) categories.

VI. Health Education and Advocacy Unit (HEAU)

The Maryland General Assembly established the 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 7 working days from the date the carrier received the request. The HEAU also gathers information about the patient's condition from the patient and his or her 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.

HEAU Statistics FY 2019

The HEAU Appeals and Grievances data[9] are reported in the charts and tables contained on pages 33-51 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 2019.

The HEAU closed 1,974 cases in FY 2019.

1. 48% 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. 14% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection-related issues.

3. 808 of the complaints closed by the HEAU were appeals and grievances related cases. Not all of the 808 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 another more appropriate agency. Of the 808 appeals and grievances cases the HEAU closed during FY 2019, 565 or 70% involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 565 cases involved more than one carrier.

4. Of the 565 appeals and grievances cases the HEAU mediated during FY 2019, 27% were adverse decision (*medical necessity*) cases, 57% were coverage decision (*contractual exclusion*) cases, and 16% were eligibility cases.

5. The HEAU mediation process resulted in 55% of the medical necessity cases, 52% of the coverage decision cases, and 53% of the eligibility denial cases being overturned or modified.

6. HEAU mediation efforts resulted in a decision change of 59% in cases involving at least one MIA-regulated plan. In cases involving non-regulated plans, the HEAU efforts resulted in a decision change 48% of the time.

7. In FY 2019, the HEAU assisted patients in recovering or saving nearly $2.5 million dollars, including over $1.9 million in appeals and grievances cases.

[9] 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.

VII. Successes and Areas of Concern

Maryland's Appeals and Grievances Law and the assistance provided by the HEAU continue to provide significant benefits to consumers. As the report indicates, 53% 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 burden for consumers.

Several examples of the HEAU's day-to-day case work highlight the importance of the consumer assistance the HEAU provides:

1. A 58-year-old consumer fell off a ladder from a height of approximately 23 feet, causing severe trauma to his face, jaws and teeth. The consumer had an insurance policy with dental benefits and medical benefits. Due to the nature of the injuries, the insurance carrier pre-authorized the services rendered by a dentist to be reimbursed under the medical benefits. Because the dentist submitted a dental claim form, rather than a medical claim form, the claim was processed under the dental benefits and was denied. The dentist was unable to convince the insurance carrier to process the dental claim form under the medical benefits. The HEAU intervened and the insurance carrier agreed to process the dental claim form as a medical benefit, reimbursing $4,270 and leaving the consumer with only a $40 copayment.

2. A 44-year-old consumer was diagnosed with a chronic incarcerated left inguinal hernia. It had ruptured and needed immediate repair. The complex repair procedure required pre-authorization from the carrier. The provider obtained the necessary approval to perform the surgery. Upon completion of the procedure, the physician removed a minor skin tag that was adjacent to the incision. The skin tag removal was considered cosmetic. The provider and the patient had previously discussed that the skin tag would be removed following the primary procedure while he was still under general anesthesia. The provider submitted a $7,132.36 claim to the carrier for processing. The claim listed all of the procedures that were performed during the surgery, including the primary procedure, repair of the inguinal hernia, and the removal of the skin tag. The carrier denied the entire surgery, citing it was a cosmetic procedure and thereby excluded from coverage. The HEAU appealed the denial and the carrier approved coverage for the hernia repair.

3. The mother of a minor consumer contacted the HEAU after attempting to refill a medication needed by her daughter for a rare endocrine disorder. The copayment for the medication had increased from $150 to $764.50 for a 90-day supply after her federal employee pharmacy benefit manager moved the drug to Tier 3, its non-preferred drug list. The HEAU assisted the consumer in obtaining a renewable formulary tier exception through the end of 2019.

4. A 27-year-old consumer was admitted to a residential substance use disorder rehabilitation treatment facility to address severe alcohol use disorder and other substance use disorders. His self-funded health plan authorized only thirteen days of residential treatment. The provider opined that it was in the patient's best interest to remain in residential treatment for at least an additional three days, but the carrier

denied coverage for the additional days, stating the member could continue treatment in an intensive outpatient setting. The consumer remained in the facility for an additional three days in accordance with the medical advice that the patient had been provided. The HEAU assisted the consumer in appealing the denial of inpatient days, resulting in the claim being approved and paid, saving the patient $3,270.

5. A consumer, insured through a county government EPO, presented to the hospital for childbirth after ensuring her OB/GYN and the hospital were in-network providers. Following the birth, a hospital-based pediatrician examined her newborn each day the baby was in the hospital. The consumer assumed that since the pediatric exam was required, and that all providers rendering care thus far were in-network, the same would be true of the examining pediatrician. Upon discharge from the hospital, the consumer received a bill from an out-of-network pediatric medical group (a group that many consumers complain about) for $1,456. When she reviewed the insurance carrier's Explanation of Benefits statement, it revealed that the claim from the pediatric medical group was denied because the services were provided by an out-of-network provider. The HEAU assisted the consumer in appealing the denial, resulting in the claim being approved and paid.

6. A newly-delivered infant, insured through a county government plan, was examined by an out-of-network, hospital-based, pediatric medical group provider. The infant's family was balance billed $1,175 by the pediatric group after the claim was processed as an out-of-network claim. Significantly, the infant's mother had previously delivered a baby at the same hospital and was balance billed by the same provider group. Wishing to avoid being balance billed again, she specifically asked that her newborn not be seen by that group. Despite assurances that she would not be balance billed by the non-participating pediatric group again, she was. The HEAU communicated with the hospital and assisted the consumer in appealing the denial, resulting in the consumer owing only her co-insurance amount.

7. An eight-month pregnant consumer, insured through a county government PPO, began to experience major discomfort. She went to an in-network hospital's emergency department. Once there it was determined that an emergency caesarian delivery would be necessary. She was admitted as an in-patient and her baby was delivered via caesarian by an in-network surgeon and an out-of-network physician assistant. Following her discharge from the facility, the surgical services provider submitted a $6,692 claim for the physician assistant's services. The carrier processed the claim as out-of-network, making a total payment of $657.60. The provider filed a complaint on behalf of the patient requesting assistance in appealing the partial payment. The HEAU appealed the denial, resulting in full payment of the claim.

8. A 22-year-old consumer, insured through a federal employee health benefit plan, went to an in-network hospital emergency room at approximately 1:00 a.m. complaining of acute abdominal pain. Based on an MRI, a diagnosis of acute appendicitis was made and emergency surgery was advised. The out-of-network, on-call surgeon was called and he performed an evaluation, for which he charged $3,000, and performed an emergency laparoscopic appendectomy, for which he charged $15,000. The carrier processed the surgeon's claim and reimbursed $2,333.95. On appeal, the insurance carrier declined to pay any additional reimbursement. The patient was responsible for

the remaining balance of $15,666.05. The patient was unable to engage the surgeon in any negotiation of the balance. The HEAU was able to negotiate a settlement of the remaining balance so that the patient was responsible only for $2,000, saving the patient $13,666.05.

The HEAU evaluated and addressed many marketplace concerns throughout the year, some new and some recurring. New concerns included the imposition of co-payment accumulator programs on prescription drug benefits; recent Medicare DNA testing scams and Medicare medical equipment scams necessitating alerts to consumers; the recent influx of CBD products in the marketplace; vaping illnesses and deaths; the Maryland Health Benefit Exchange's proposed regulations and plan certification standards, and proposed revisions to the State Benchmark Plan, all necessitating comments by the HEAU; and collaboration with the Maryland Health Benefit Exchange, the Comptroller's office and other stakeholders on the Maryland Easy Enrollment Health Insurance Program. Finally, we have received some complaints about the integrity and security of electronic medical records and are analyzing whether there are gaps in protections and remedies for consumers.

The HEAU's 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 State Benchmark Plan Workgroup; the Health Insurance Consumer Protections Workgroup; and the Maryland Health Care Commission's Health Information Exchange Advisory Workgroup.

The HEAU also provided consultative and litigation support to the Office in its efforts to 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, *inter alia*, supporting State efforts to regulate pharmacy benefit managers' (PBM) drug-reimbursement rates; opposing efforts to defund Planned Parenthood; opposing efforts to roll back mandated contraceptive coverage; and supporting efforts to require mandated risk-corridor payments to health plans by the federal government. In addition, the HEAU worked with the Office and others to comment on federal regulations and other policies threatening to undermine protections for the health of the residents of the State and for the availability of affordable health care, e.g. regulations unlawfully eliminating anti-discrimination protections, allowing states to obtain waivers from critical requirements of the ACA and amending the "public charge" rule. The HEAU also assisted the Office in the preparation of comments regarding federal regulation of products containing cannabis or cannabis-derived compounds and regulations updating the federal Contact Lens Rule. The HEAU also contributed to comments seeking reauthorization of the Autism CARES Act.

The HEAU continued to address several recurring concerns during FY 2019, including surprise and balance billing; patients' bill of rights; mental health parity; network adequacy standards; consumers' rights to access medical records and obtain affordable copies under HIPAA; the integrity and security of electronic medical records; medical privacy threats; consumer protections on the State's Health Information Exchange and State's Health Benefit Exchange; advanced medical directives; access to affordable prescription drugs, including the detrimental impact that business practices of PBMs and carriers (e.g. below-cost reimbursements, specialty pharmacy requirements, electronic prescribing) may have on access and affordability; the opioid crisis; and medical cannabis advertising.

The HEAU is focused on several other Areas of Concern:

A. Outpatient Facility Fees

In an effort to protect consumers from surprising and excessive outpatient facility fees charged by hospitals (see complaints described in the 2016, 2017 and 2018 Annual Reports), the HEAU actively supported the 2019 Facility Fee Right to Know Act, Senate Bill 803 (Sen. Kelley)/House Bill 849 (Del. R. Lewis)(unanimously passed in each chamber before crossover), which would have mandated specific oral and written notice of the existence and amount of the hospital's facility fees, or a low-high range of the fees, at the time consumers make outpatient appointments. Consumers need to be notified about these unexpected fees, and should be provided with material price information, at the time they make appointments so they may go somewhere else without a hospital fee, if they wish or need to do so.

During the 2019 legislative session, many legislators questioned why outpatients are charged facility fees in addition to the professional fees charged by providers performing physician services that usually are provided in an office setting, and why the fees are so high. From a consumer perspective, the prevalence and amount of facility fees seem to warrant a full evaluation, but the HEAU's priority was passage of meaningful notice legislation so that consumers would avoid surprise bills, as reflected in the HEAU's many complaints.

The seemingly unjustifiable increase in consumers' out of pocket costs, as well as overall costs to the health care system, suggest a full evaluation is necessary. And, the lack of notice to consumers simply compels remedial action, whether through enforcement of general protections afforded by the Consumer Protection Act or through enactment of legislation that specifically addresses the problem. The following statements are representative of consumers' distress about current practices:

> "I object to the bill since (1) the fee was NOT disclosed to me & had I been given the choice, & made aware, I would have gone elsewhere with no fee (2) the fee seems EXCESSIVE & UNUSUALLY HIGH above what is usual & customary charge for a visit (3) it presents a financial hardship to me that could have been avoided had it been disclosed (4) I have repeatedly asked the [hospital] to either forgive or reduce the remaining balance due to something more reasonable (more like $200-350 which is still charging me twice for the same appointment!)….I think if a fee is so large, the patient should be warned there could be [a] fee, and how much the fee will be so they can make an informed decision if they want to pursue the treatment. Most people would only expect a doctor's office visit fee, not a fee to pay the hospital to use their space!"

> "…, my complaint centers on the [hospital's] practice of charging a substantial hospital user fee for patients who have routine doctor office visits two blocks away from the hospital in an entirely separate building - an office building. Moreover and in my case, the assignment of these fees were done without any prior notice to me, the patient. Finally, the amount of the fee, again - at least in my case, was more than eight times the amount of the charge for the office visit itself!"

"...[my doctor] keeps appointment hours at suburban locations; if I had been aware of the usage fee policy in advance, I could have chosen (as I have in the past) to see him at these alternate venues. The absence of proper notification of patients both at the time of scheduling and at the appointment itself also smacks of abuse of the patient/consumer."

B. Prescription Drug Pricing

The HEAU and the MIA received numerous complaints in FY 2019 about pharmacy-related problems, including complaints related to the high cost of prescription drugs. Of the Appeals and Grievances cases mediated and closed by the HEAU, 11% were pharmacy-related. In addition, 38% of the grievances filed with the MIA were pharmacy-related. The persistent lack of transparency about pricing and reimbursement practices, and the aggressive efforts of dominant market players to reduce or eliminate competition, continue to threaten consumer access to affordable prescription drugs. The HEAU supports the MIA's interim workgroup's efforts to strengthen regulatory controls over PBMs, particularly their reimbursement practices, and is participating in the Maryland Department of Health's interim workgroup on mandatory electronic prescribing for all prescription drugs. The HEAU had concerns about the 2019 e-prescribing legislation's potential impact on individual access and competition in the marketplace, among other issues. The HEAU will closely monitor the activities of the newly created Prescription Drug Affordability Board established to protect stakeholders from the high costs of prescription drugs, and to monitor pharmacy-related complaints for drug pricing and coverage issues that may merit future legislative action.

C. Personal Information Protection

The HEAU has been advocating for consumer protections increasing genetic privacy protections related to direct-to-consumer (DTC) genetic testing since the products started expanding five years ago. The HEAU believes additional privacy protections are needed because of the proliferation and increased advertising of non-medical DTC genetic testing products (e.g. ancestry, athletic ability, and wine preferences) and the lack of transparency about how companies sell or disclose genetic information.

The HEAU believes that the General Assembly should consider amending Maryland's Personal Information Protection Act (PIPA) to expand the scope of personal information protected by PIPA to include additional sensitive and private genetic information that is being harvested from consumers for profit. To protect genetic information, the definition of personal information should be expanded to include genetic information with respect to an individual, including an individual's genetic sample; an individual's genetic tests; the genetic tests of family members of the individual; the manifestation of a disease or disorder in family members of such individual; any request for, or receipt of, a genetic test, genetic counseling, or genetic education; and any information or data derived therefrom. These amendments would require businesses to implement and maintain reasonable security practices and procedures to protect genetic information from unauthorized access, use, modification, or disclosure. Reasonable security practices necessarily include protections such as encryption, which leading subject matter experts now consider feasible and essential to the protection of genetic information contained in the raw data posted by tested consumers without the consent of untested genetic relatives.

Similarly, the HEAU believes that the General Assembly should consider amending PIPA to expand the scope of personal information protected by PIPA to include activity-tracking data that could include health-related activities.

VIII. Conclusion

Maryland continues to be a leader and innovator in the health care marketplace. As the marketplace rapidly and significantly evolves we must strive to remain aware of barriers to consumers receiving coverage and care. The HEAU will continue to be the voice of and advocate for the ultimate beneficiaries of the marketplace – the patients.

Appendix

Carrier Cases
Adverse Decisions, Grievances and Outcomes

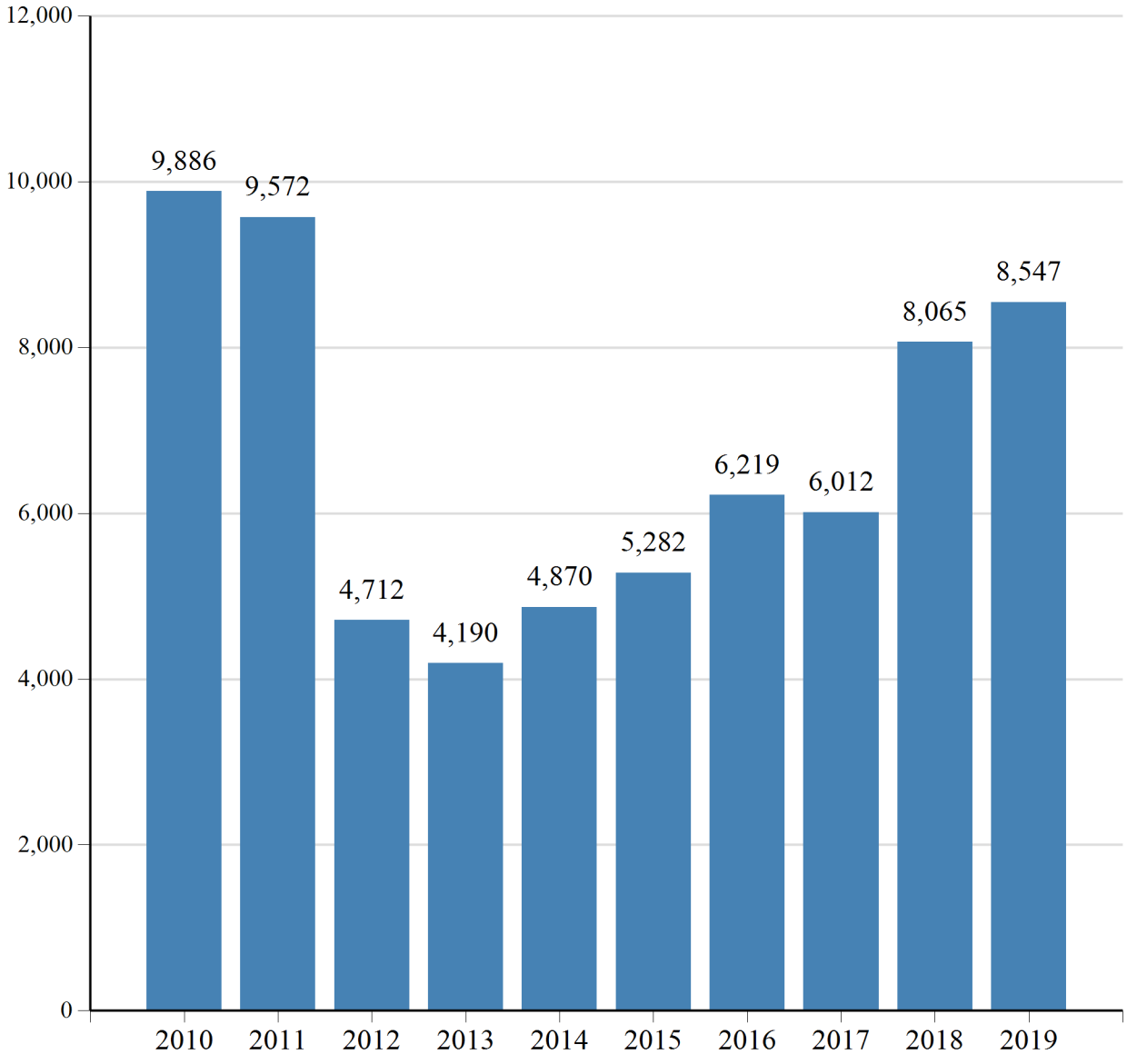
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Aetna Dental Inc.	627	0	0	0%	0%
Aetna Health Inc. (a Pennsylvania corporation)	218	46	344	55%	45%
Aetna Life Insurance Company	199	34	216	52%	48%
Ameritas Life Insurance Corp.	98	0	48	46%	54%
CareFirst BlueChoice, Inc.	19,993	0	2,287	49%	51%
Carefirst of Maryland, Inc.	8,141	0	845	46%	54%
Chesapeake Life Insurance Company	0	0	1	100%	0%
CIGNA Dental Health of Maryland, Inc.	44	0	0	0%	0%
CIGNA Health and Life Insurance Company	8,186	40	522	58%	42%
Combined Insurance Company of America	0	0	1	0%	100%
Connecticut General Life Insurance Company	6	0	0	0%	0%
Delta Dental Insurance Company	24	0	0	0%	0%
Delta Dental of Pennsylvania	65	0	0	0%	0%
Dental Benefit Providers of Illinois, Inc.	3,113	0	237	12%	88%
Dentegra Insurance Company	2	0	0	0%	0%
Dominion Dental Services, Inc.	347	0	94	47%	53%
Golden Rule Insurance Company	25	0	14	100%	0%
Group Dental Service of Maryland, Inc.	3,533	0	0	0%	0%
Group Hospitalization and Medical Services, Inc.	7,448	0	914	46%	54%
Guarantee Trust Life Insurance Company	0	0	2	100%	0%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Guardian Life Insurance Company of America	856	0	482	44%	56%
Johns Hopkins HealthCare LLC	56	0	208	45%	55%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	708	0	36	86%	14%
Kaiser Permanente Insurance Company	82	0	17	71%	29%
Lincoln Life & Annuity Company of New York	2	1	0	0%	0%
Lincoln National Life Insurance Company	162	54	0	0%	0%
MAMSI Life and Health Insurance Company	1,751	0	159	33%	67%
Metropolitan Life Insurance Company	386	42	47	49%	51%
National Health Insurance Company	5	0	1	100%	0%
Optimum Choice, Inc.	2,804	0	215	50%	50%
Principal Life Insurance Company	398	0	90	88%	12%
Reliance Standard Life Insurance Company	9	0	2	100%	0%
Standard Insurance Company	33	0	5	40%	60%
Starmount Life Insurance Company	2	0	2	50%	50%
Unicare Life & Health Insurance Company	0	0	1	100%	0%
Union Security Insurance Company	566	0	53	60%	40%
United Concordia Dental Plans, Inc.	1	0	1	100%	0%
United Concordia Insurance Company	828	0	442	33%	67%
UnitedHealthcare Insurance Company	12,949	0	1,213	37%	63%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
UnitedHealthcare of the Mid-Atlantic, Inc.	1,537	0	48	40%	60%
Totals	**75,204**	**217**	**8,547**	**46%**	**54%**

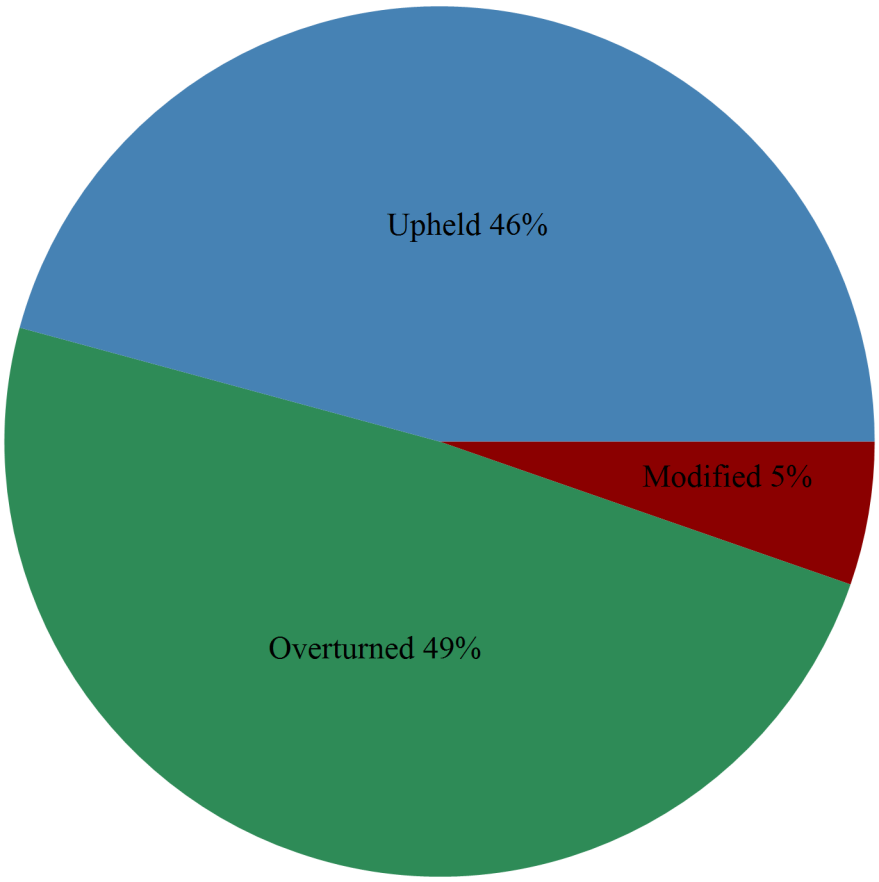
Carrier Grievances Cases
Number of Grievances Since Fiscal Year 2010

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.



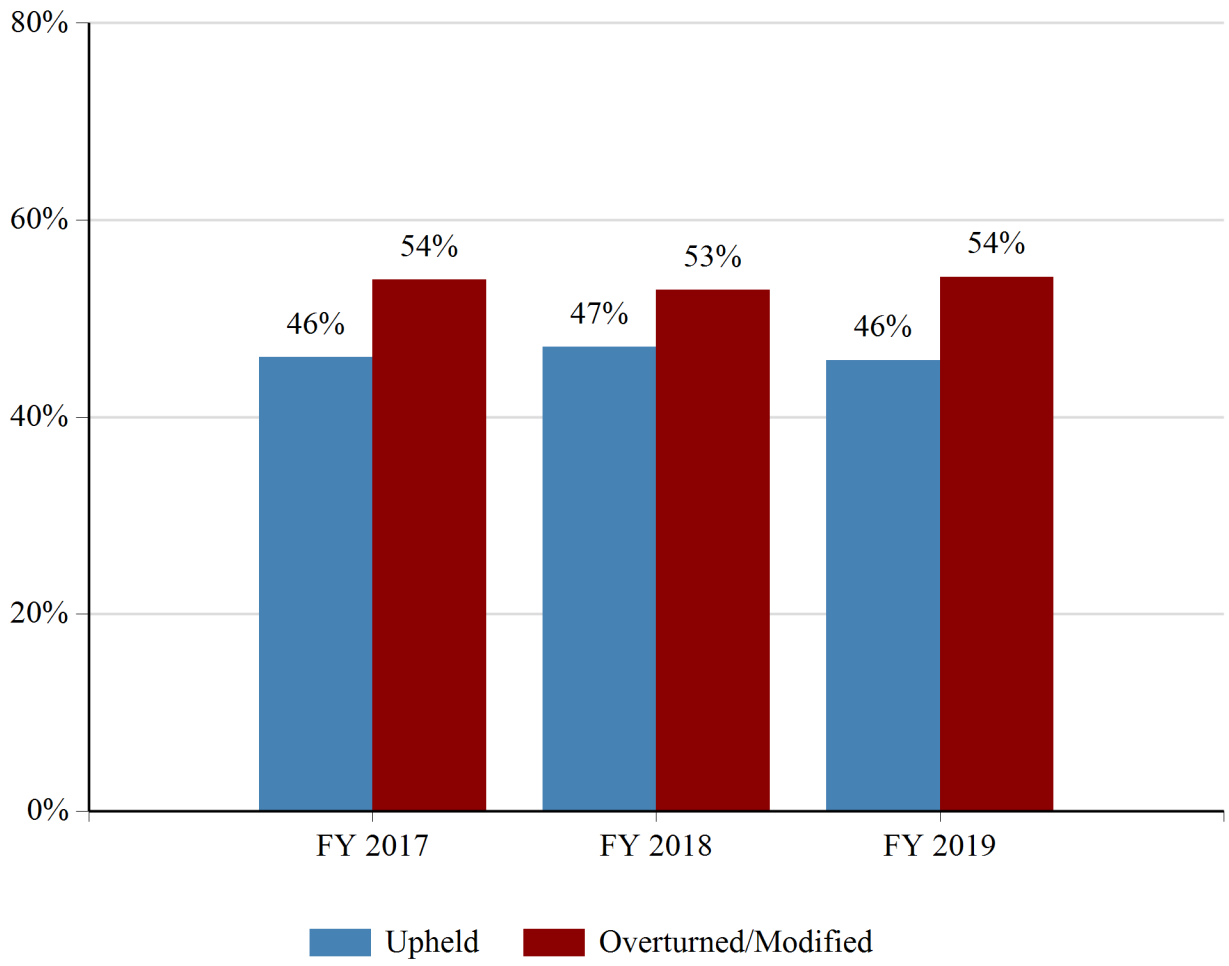
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 8,547 internal grievances filed with carriers in FY 2019, 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 2019, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	18,146	24.129%	2,372	27.752%
Durable Medical Equipment	1,305	1.735%	147	1.720%
Emergency Room	16	0.021%	30	0.351%
Home Health	133	0.177%	6	0.070%
Inpatient Hospital	1,175	1.562%	229	2.679%
Laboratory, Radiology	11,792	15.680%	1,304	15.257%
Mental Health / Substance Abuse	790	1.050%	108	1.264%
Other*	489	0.650%	153	1.790%
Pharmacy	31,300	41.620%	3,468	40.576%
Physician	7,268	9.664%	632	7.394%
PT, OT, ST, including inpatient rehabilitation	2,757	3.666%	82	0.959%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	33	0.044%	16	0.187%
Totals	**75,204**	**100%**	**8,547**	**100%**

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

Carrier Grievances Cases
Outcomes by Service Type

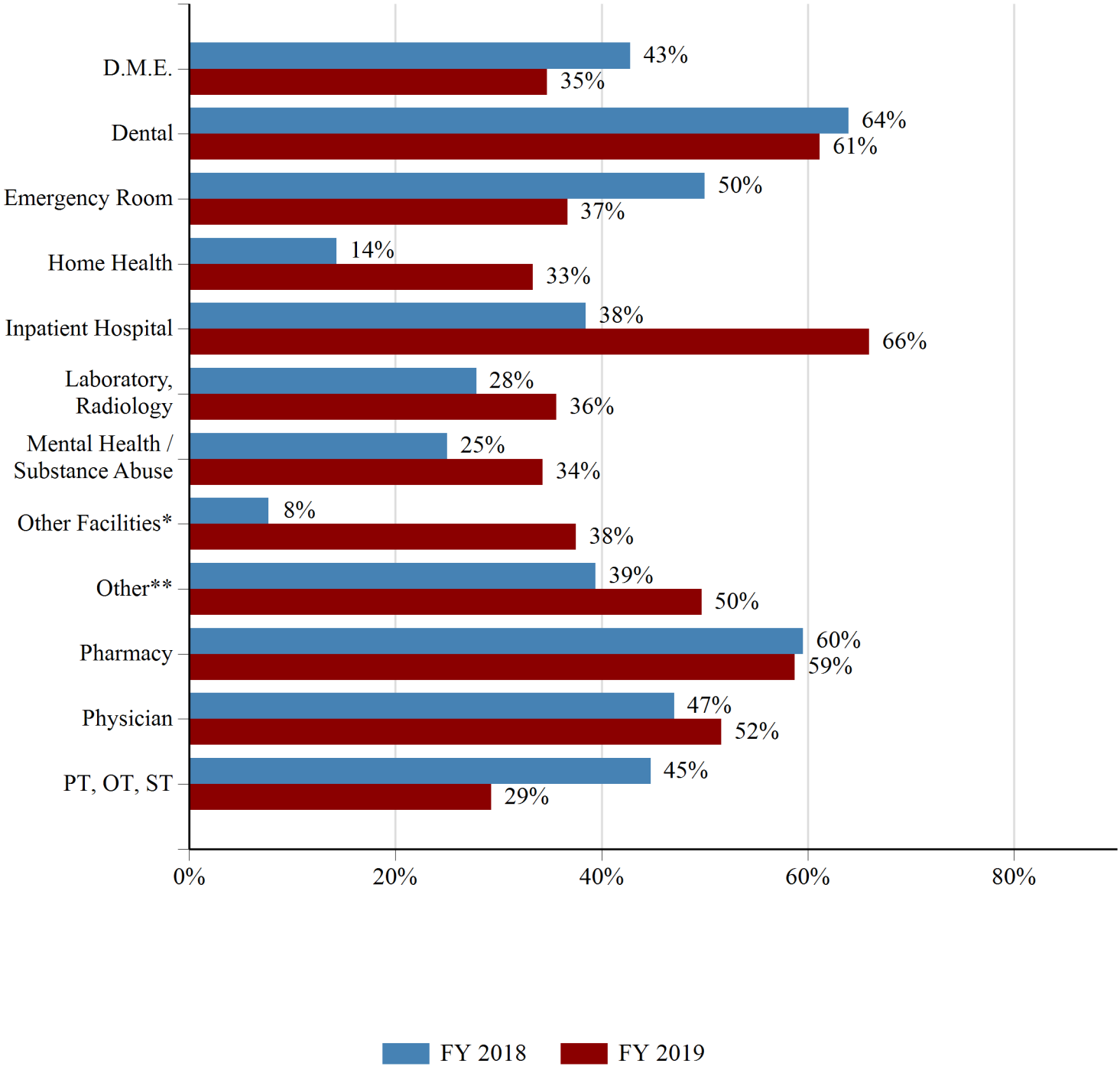
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Dental	2,372	39%	61%
Durable Medical Equipment	147	65%	35%
Emergency Room	30	63%	37%
Home Health	6	67%	33%
Inpatient Hospital	229	34%	66%
Laboratory, Radiology	1,304	64%	36%
Mental Health / Substance Abuse	108	66%	34%
Other*	153	50%	50%
Pharmacy	3,468	41%	59%
Physician	632	48%	52%
PT, OT, ST, including inpatient rehabilitation	82	71%	29%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	16	63%	38%
Totals	**8,547**	**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 2018 and FY 2019.

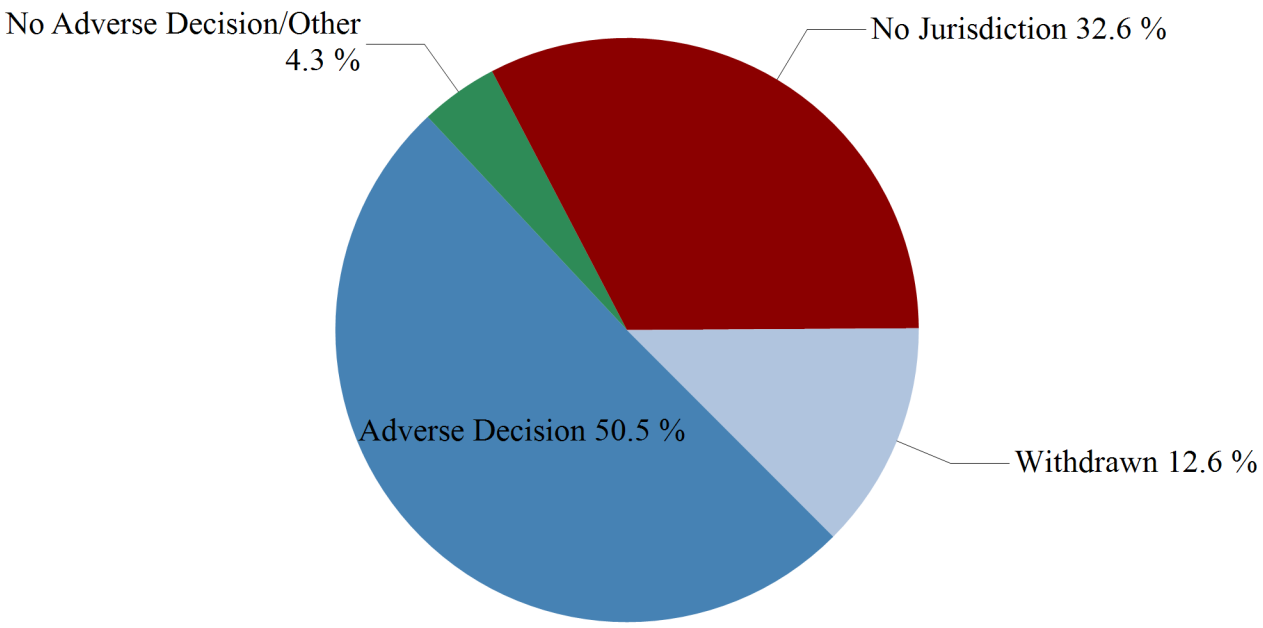


* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.
** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints
Initial Review of Cases

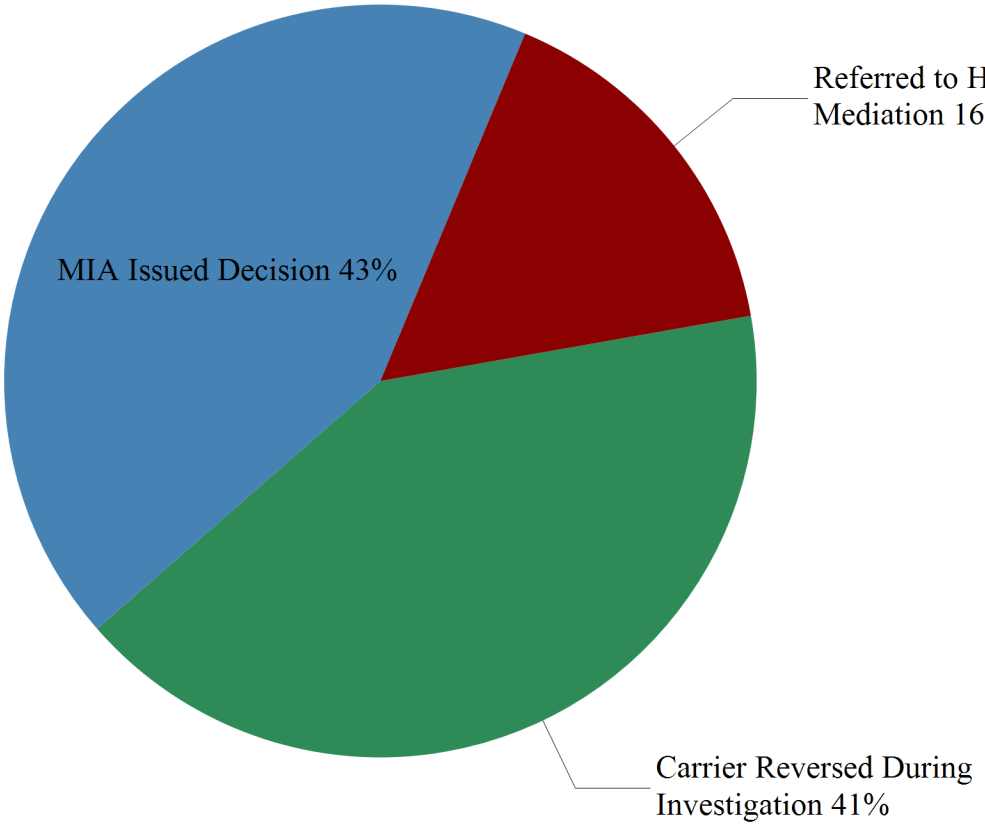
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some 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 857 cases filed with the MIA's Appeals and Grievances Unit during FY 2019.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2019, the MIA determined that 433 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 69 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 433 grievances the MIA reviewed during FY 2019.



MIA Appeals and Grievances Cases
Carriers and Disposition

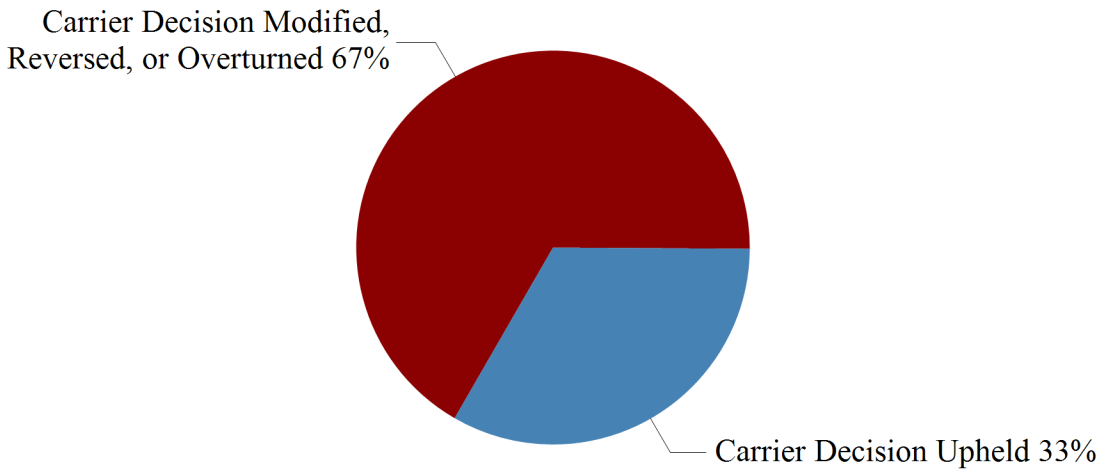
The table below details the outcomes of the 364 grievances complaints the MIA investigated during FY 2019. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	13	8	61.5%	2	15.4%	0	0.0%	3	23.1%
Aetna Life Insurance Company	4	3	75.0%	1	25.0%	0	0.0%	0	0.0%
CareFirst BlueChoice, Inc.	72	24	33.3%	6	8.3%	0	0.0%	42	58.3%
Carefirst of Maryland, Inc.	105	30	28.6%	19	18.1%	0	0.0%	56	53.3%
CaremarkPCS Health L.L.C.	14	4	28.6%	0	0.0%	0	0.0%	10	71.4%
CIGNA Dental Health of Maryland, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
CIGNA Health and Life Insurance Company	18	5	27.8%	7	38.9%	0	0.0%	6	33.3%
Delta Dental Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Delta Dental of Pennsylvania	3	0	0.0%	1	33.3%	0	0.0%	2	66.7%
Express Scripts Insurance Company	1	0	0.0%	1	100.0%	0	0.0%	0	0.0%
Golden Rule Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Group Hospitalization and Medical Services, Inc.	17	9	52.9%	3	17.6%	0	0.0%	5	29.4%
Guardian Life Insurance Company of America	11	6	54.5%	2	18.2%	0	0.0%	3	27.3%
Johns Hopkins University	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	7	4	57.1%	2	28.6%	0	0.0%	1	14.3%
Kaiser Permanente Insurance Company	2	0	0.0%	1	50.0%	0	0.0%	1	50.0%

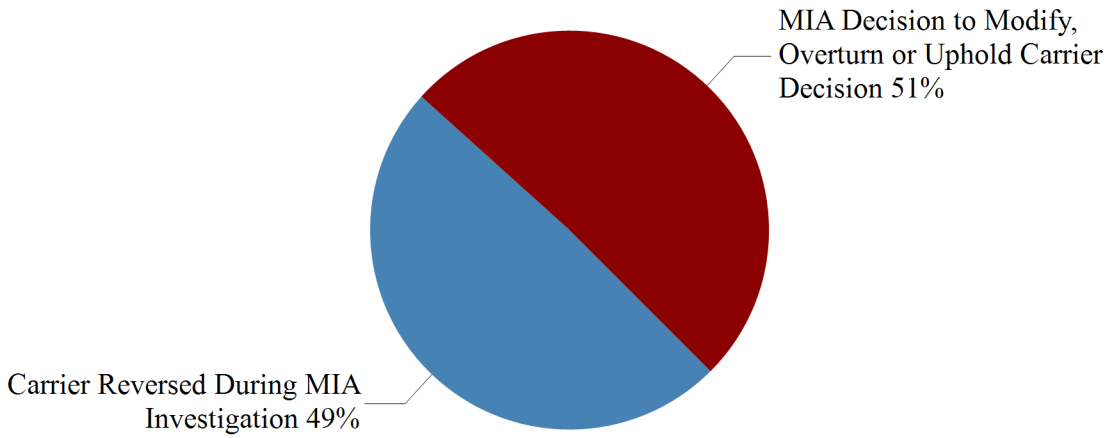
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
MAMSI Life and Health Insurance Company	7	4	57.1%	0	0.0%	0	0.0%	3	42.9%
Metropolitan Life Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Optimum Choice, Inc.	4	1	25.0%	0	0.0%	0	0.0%	3	75.0%
Principal Life Insurance Company	3	0	0.0%	1	33.3%	0	0.0%	2	66.7%
United Concordia Insurance Company	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
United Concordia Life and Health Insurance Company	8	4	50.0%	2	25.0%	0	0.0%	2	25.0%
UnitedHealthcare Insurance Company	60	17	28.3%	9	15.0%	2	3.3%	32	53.3%
UnitedHealthcare of the Mid-Atlantic, Inc.	7	0	0.0%	4	57.1%	0	0.0%	3	42.9%
UnitedHealthcare Services, Inc.	1	0	0.0%	1	100.0%	0	0.0%	0	0.0%
Totals	**364**	**121**	**33%**	**62**	**17%**	**2**	**1%**	**179**	**49%**

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 364 grievances the MIA investigated during FY 2019.

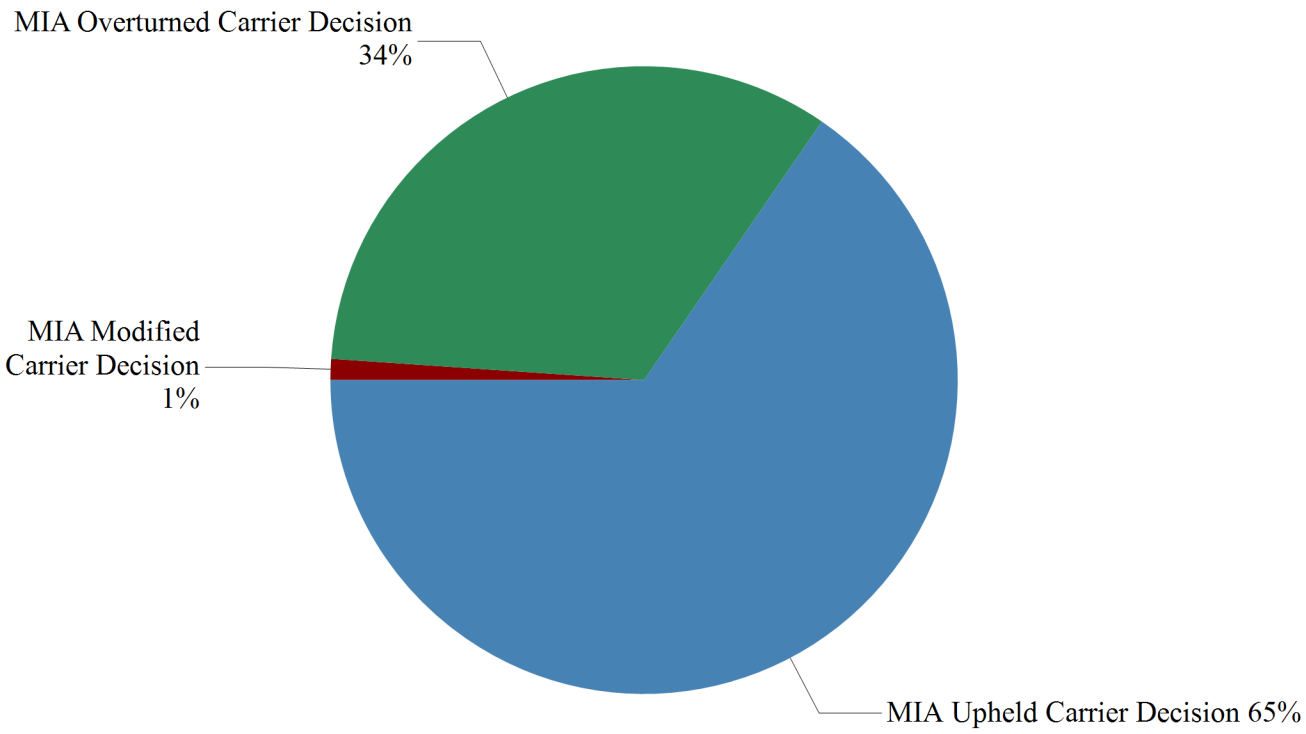


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 185 cases the MIA forwarded to an IRO for review in FY 2019.



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 2019. 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.

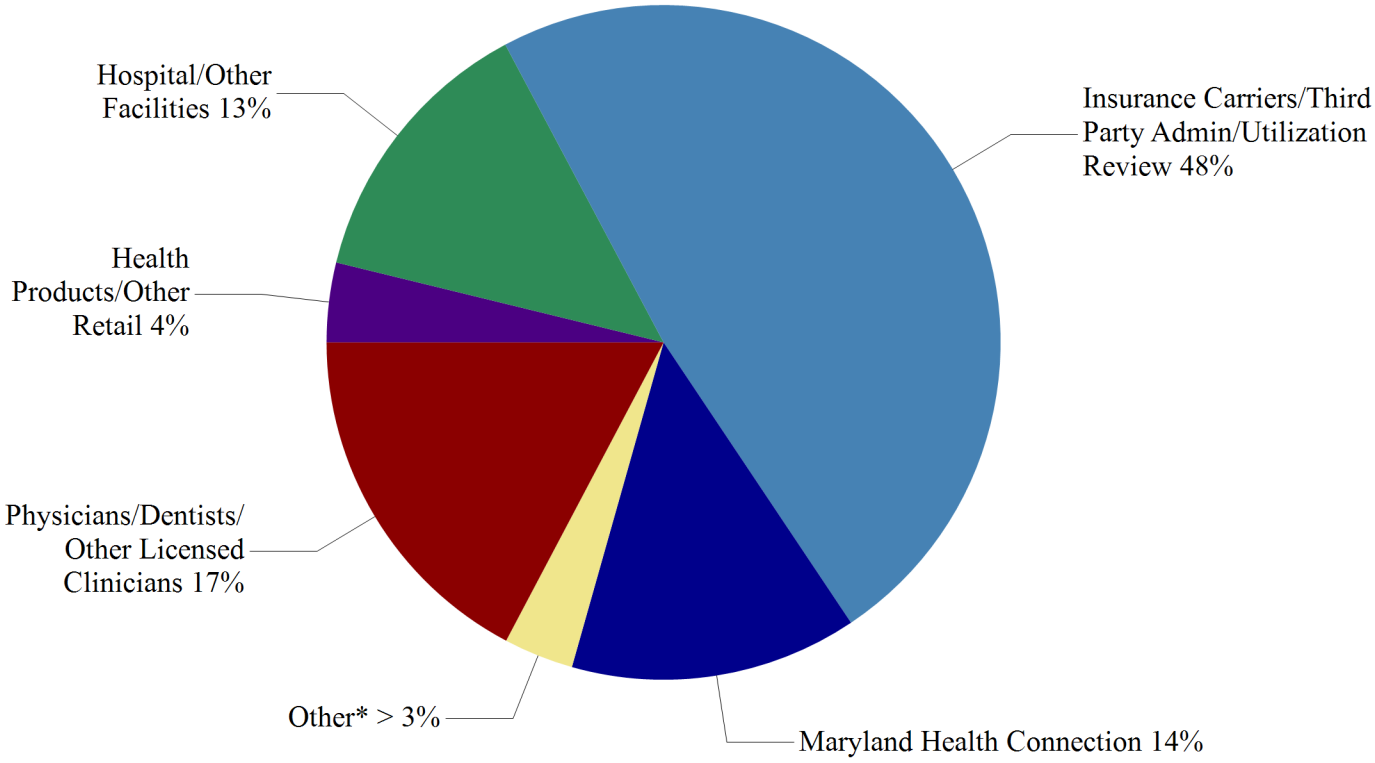
Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Air Ambulance	2	<1 %	1	50%	1	50%	0	0%	0	0%
Chiropractic Care Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Cosmetic	5	1%	1	20%	2	40%	0	0%	2	40%
Denial of Hospital Days	10	3%	5	50%	2	20%	0	0%	3	30%
Dental Care Services	79	22%	26	33%	12	15%	0	0%	41	52%
Durable Medical Equipment	11	3%	5	45%	2	18%	0	0%	4	36%
Emergency Room Denial	4	1%	0	0%	0	0%	0	0%	4	100%
Experimental	35	10%	27	77%	5	14%	0	0%	3	9%
Eye Care Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Home Care Services	2	<1 %	0	0%	1	50%	0	0%	1	50%
In-Patient Rehabilitation Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Lab, Imaging, Test Services	20	5%	8	40%	3	15%	0	0%	9	45%
Mental Health Partial Hospitalization	2	<1 %	0	0%	2	100%	0	0%	0	0%
Mental Health/Substance Abuse (Inpatient) Services	5	1%	2	40%	2	40%	1	20%	0	0%
Mental Health/Substance Abuse (Outpatient) Services	4	1%	2	50%	0	0%	1	25%	1	25%
Morbid Obesity	1	<1 %	0	0%	0	0%	0	0%	1	100%
Opioid Use Disorders	7	2%	0	0%	1	14%	0	0%	6	86%
Outpatient Services	1	<1 %	0	0%	1	100%	0	0%	0	0%
Pharmacy Benefits	4	1%	0	0%	0	0%	0	0%	4	100%
Pharmacy Services/Formulary Issues	135	37%	28	21%	18	13%	0	0%	89	66%

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Physician Services	33	9%	16	48%	10	30%	0	0%	7	21%
PT, OT, ST Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Totals	**364**	**100%**	**121**	**33%**	**62**	**17%**	**2**	**1%**	**179**	**49%**

Percentages may not equal 100% due to rounding.

HEAU Cases
Subject of Complaints

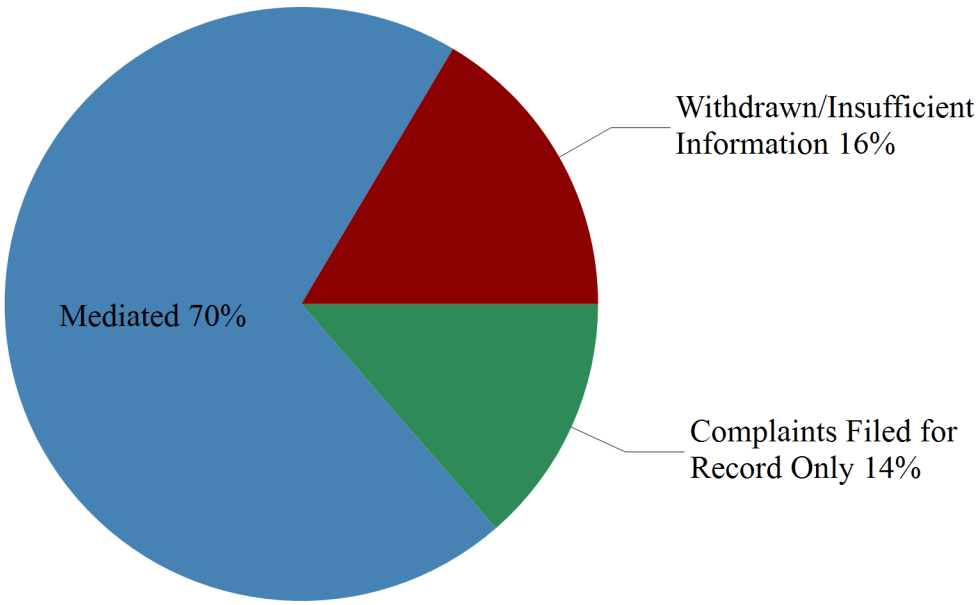
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, 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 2019. The HEAU closed 1,974 complaints. Some complaints were filed against more than one industry.



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

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 808 Appeals and Grievances cases closed by the HEAU during FY 2019.



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 2019. "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 565 cases in FY 2019. 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	
Administrative Concepts, Inc.					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Aetna Health Inc.					
State Regulated	4	0	0%	4	100%
Not State Regulated	27	13	48%	14	52%
Total Complaints	**31**	**13**	**42%**	**18**	**58%**
Anthem Blue Cross and Blue Shield					
Not State Regulated	13	10	77%	3	23%
Total Complaints	**13**	**10**	**77%**	**3**	**23%**
Anthem Blue Cross Blue Shield of MO					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Anthem Blue Cross Blue Shield Ohio					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Anthem UM Services, Inc.					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Beacon Health Options					
State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Blue Cross and Blue Shield of Louisiana					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
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 Minnesota					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Blue Cross Blue Shield of South Carolina					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
BlueCross BlueShield of Illinois					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
BlueCross BlueShield of Texas					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CareFirst					
State Regulated	98	46	47%	52	53%
Not State Regulated	62	31	50%	31	50%
Total Complaints	**160**	**77**	**48%**	**83**	**52%**
CareFirst Administrators					
Not State Regulated	3	2	67%	1	33%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
CareFirst the Dental Network					
State Regulated	12	4	33%	8	67%
Not State Regulated	2	2	100%	0	0%
Total Complaints	**14**	**6**	**43%**	**8**	**57%**

Carrier	Total Cases	Upheld		Overturned/Modified	
CIGNA					
State Regulated	10	3	30%	7	70%
Not State Regulated	41	23	56%	18	44%
Total Complaints	**51**	**26**	**51%**	**25**	**49%**
Cigna Dental					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CoreSource					
Not State Regulated	4	1	25%	3	75%
Total Complaints	**4**	**1**	**25%**	**3**	**75%**
CVS Caremark					
State Regulated	14	2	14%	12	86%
Not State Regulated	15	7	47%	8	53%
Total Complaints	**29**	**9**	**31%**	**20**	**69%**
CWI Benefits - GBS					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Davis Vision					
State Regulated	3	0	0%	3	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
Delta Dental					
State Regulated	6	5	83%	1	17%
Not State Regulated	3	3	100%	0	0%
Total Complaints	**9**	**8**	**89%**	**1**	**11%**
Delta Dental of Pennsylvania					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Delta Dental of Virginia					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Dental Select					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Dominion National					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Ebix Health Administration Exchange Inc.					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Electrical Welfare Trust Fund					
Not State Regulated	4	3	75%	1	25%
Total Complaints	**4**	**3**	**75%**	**1**	**25%**
Evergreen Health, Inc.					
State Regulated	6	0	0%	6	100%
Total Complaints	**6**	**0**	**0%**	**6**	**100%**
eviCore Healthcare					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Express Scripts					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Geisinger Health Plan					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Golden Rule Insurance					
Not 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%**
Guardian Life insurance Company of America					
State Regulated	3	1	33%	2	67%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**
Health Net Federal Services, LLC					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
HealthSCOPE Benefits					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Highmark					
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%**
IHC Health Solutions					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
International Medical Group					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
IUOE Local 99 & 99-A Health and Welfare Fund					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Johns Hopkins Employer Health Programs					
Not State Regulated	5	1	20%	4	80%
Total Complaints	**5**	**1**	**20%**	**4**	**80%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	60	33	55%	27	45%
Not State Regulated	8	4	50%	4	50%
Total Complaints	**68**	**37**	**54%**	**31**	**46%**
Magellan Behavioral Health					
State Regulated	2	1	50%	1	50%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Mail Handlers Benefit Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
MAMSI Life & Health Insurance Company					
State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Maryland Health Connection					
State Regulated	22	7	32%	15	68%
Total Complaints	**22**	**7**	**32%**	**15**	**68%**
MDIPA | UnitedHealthcare					
Not State Regulated	9	4	44%	5	56%
Total Complaints	**9**	**4**	**44%**	**5**	**56%**
Meritain Health Incorporated					
State Regulated	3	0	0%	3	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**

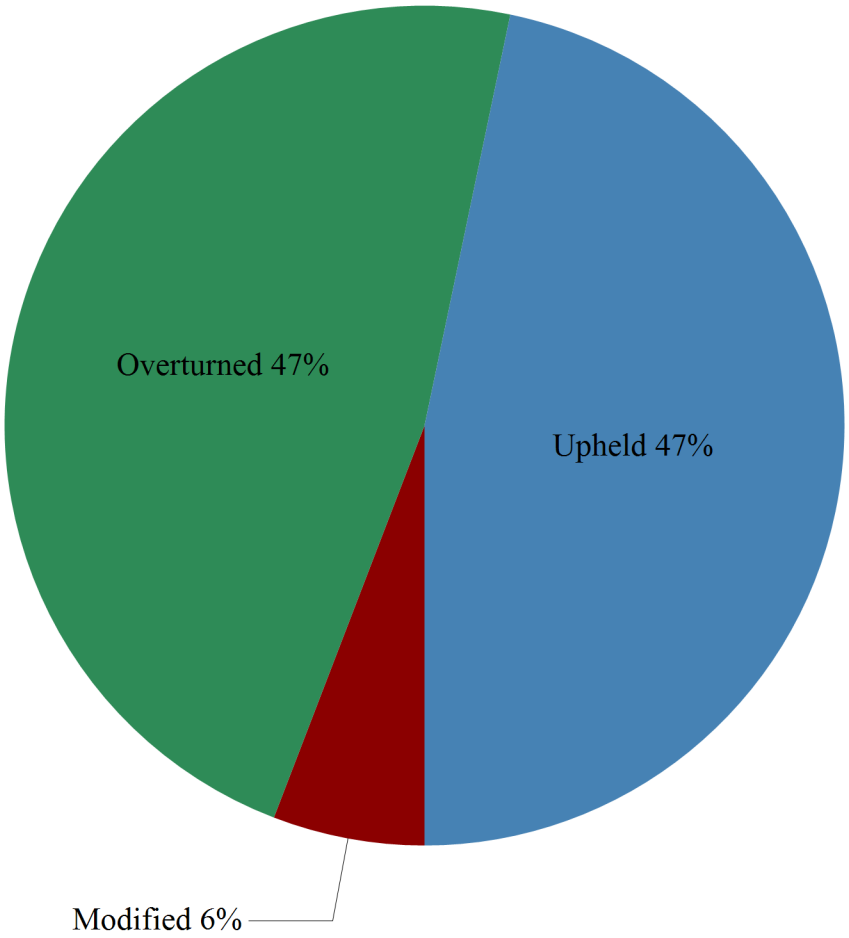
Carrier	Total Cases	Upheld		Overturned/Modified	
Metropolitan Life Insurance Company					
Not State Regulated	5	0	0%	5	100%
Total Complaints	**5**	**0**	**0%**	**5**	**100%**
Mid-Atlantic Regional Council of Carpenters' Health Fund					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
National Association of Letter Carriers Health Benefit Plan					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
National Automatic Sprinkler Industry Welfare Fund					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
National Claims Administrative Services					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
National General Accident and Health					
State Regulated	3	0	0%	3	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
Optimum Choice					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Optum					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
OptumRx, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
POMCO					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Premera Blue Cross Blue Shield of Alaska					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
QualCare, Inc.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
SAG AFTRA Health Plan					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Standard Security Life Insurance Company of New York					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
The Loomis Company					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Transamerica					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
UMR					
State Regulated	2	0	0%	2	100%
Not State Regulated	3	3	100%	0	0%
Total Complaints	**5**	**3**	**60%**	**2**	**40%**
United Behavioral Health					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**

Carrier	Total Cases	Upheld		Overturned/Modified	
United Concordia Insurance Company					
State Regulated	3	0	0%	3	100%
Not State Regulated	15	10	67%	5	33%
Total Complaints	**18**	**10**	**56%**	**8**	**44%**
UnitedHealthcare					
State Regulated	28	8	29%	20	71%
Not State Regulated	51	22	43%	29	57%
Total Complaints	**79**	**30**	**38%**	**49**	**62%**
Value Options					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Wellmark BlueCross BlueShield					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Zenith American Solutions					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**

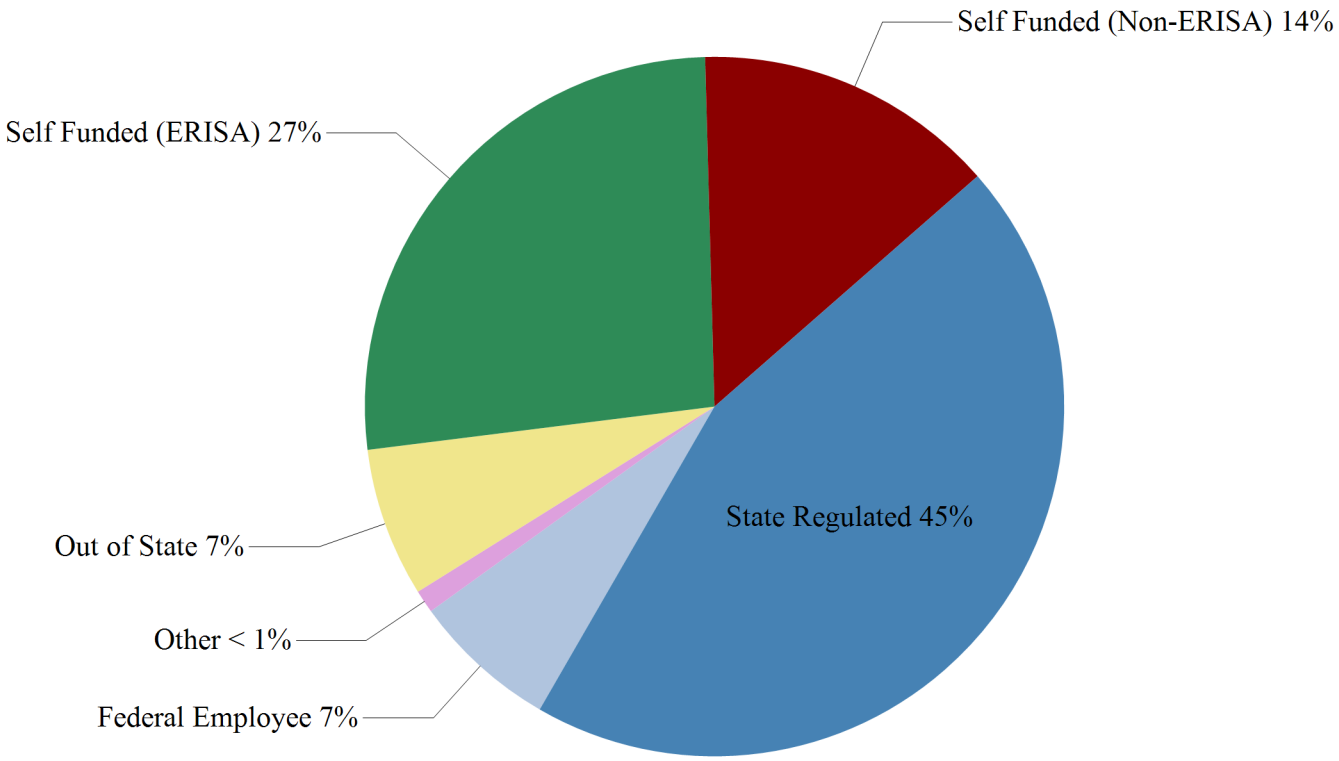
HEAU Mediated Appeals and Grievances Cases
Disposition

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 2019.



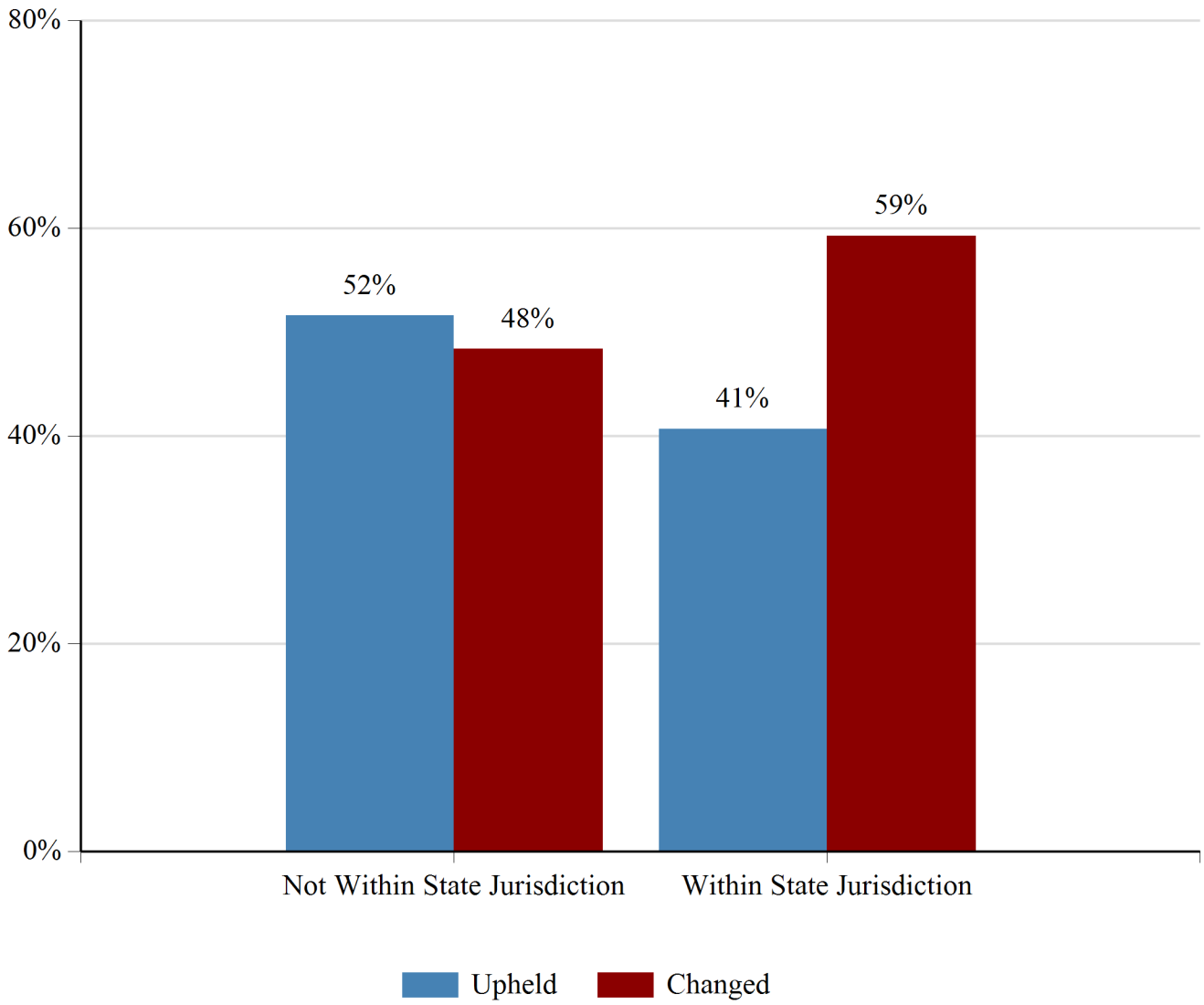
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the primary carrier types involved in the 565 Appeals and Grievances cases the HEAU mediated and closed during FY 2019.



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

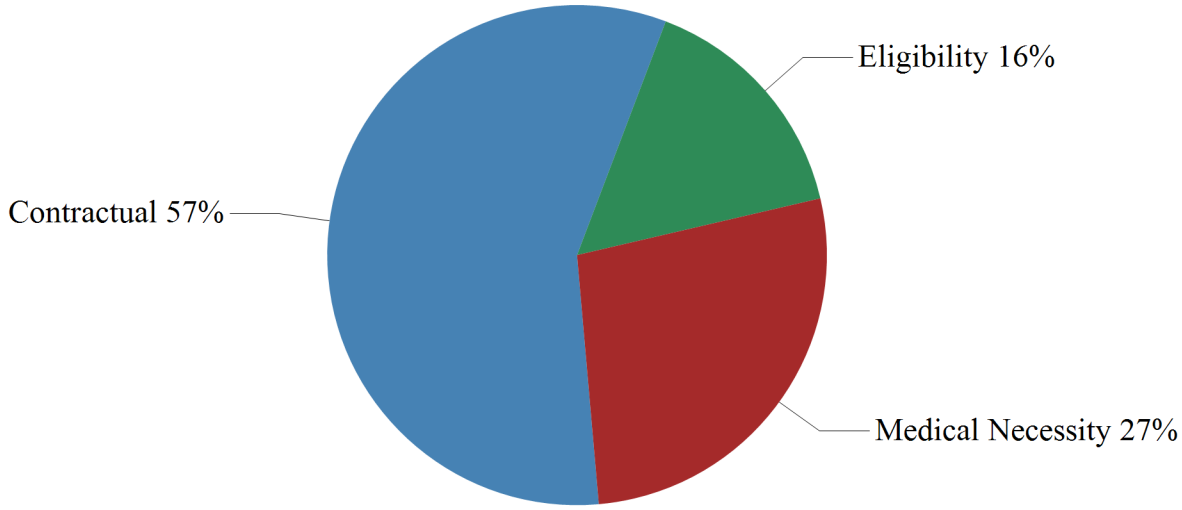
The chart below reflects the outcomes of the 565 Appeals and Grievances cases the HEAU mediated and closed during FY 2019 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

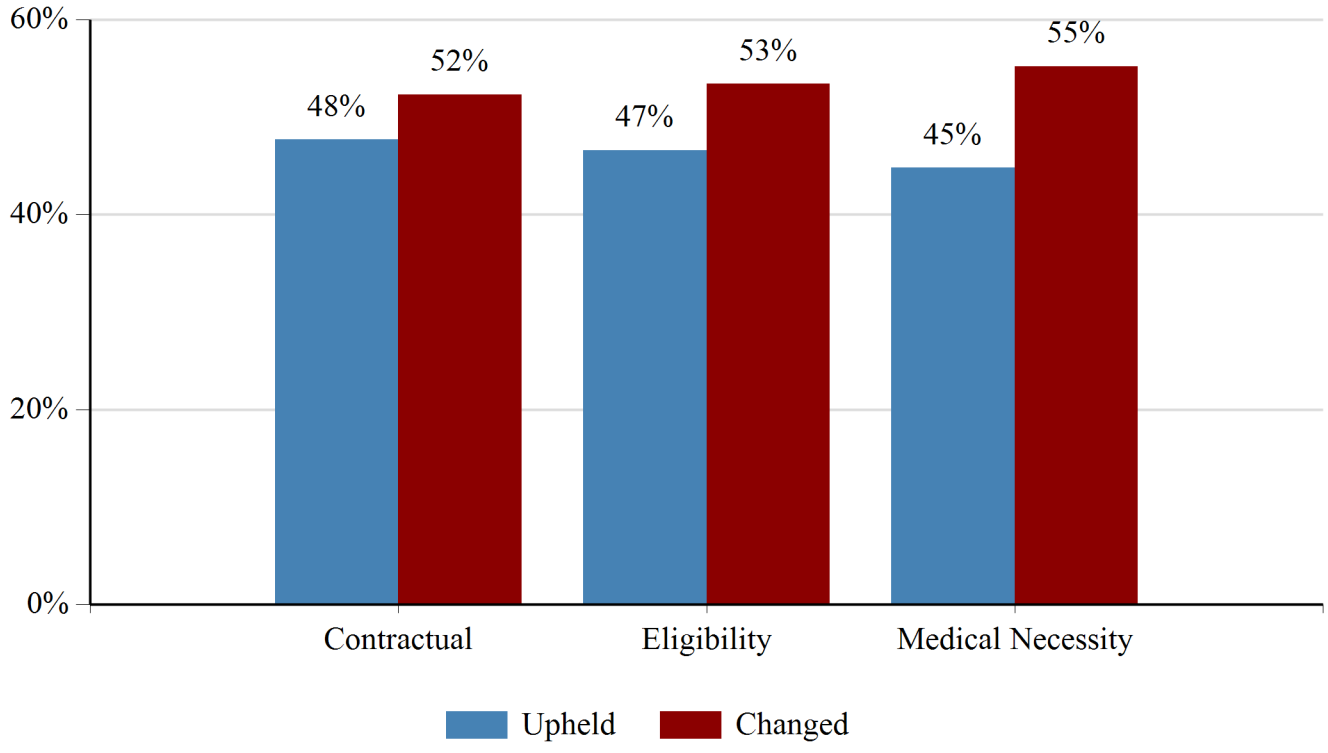
Types of Denials

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 2019.



Outcomes by Denial Type

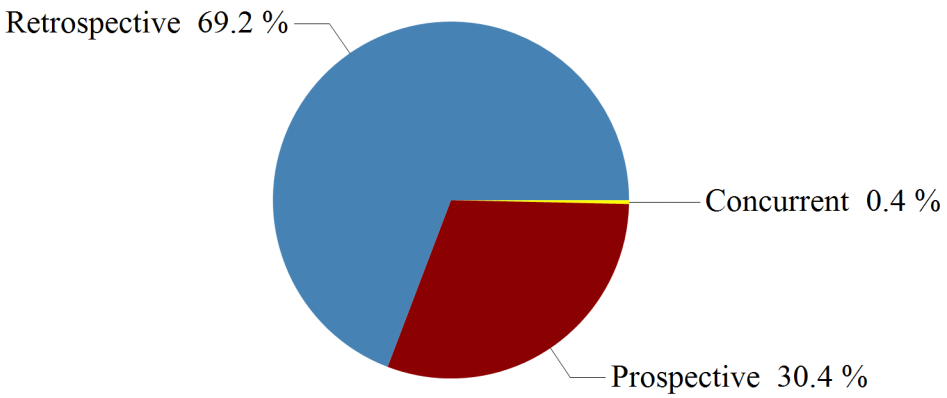
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2019.



HEAU Mediated Appeals and Grievances Cases

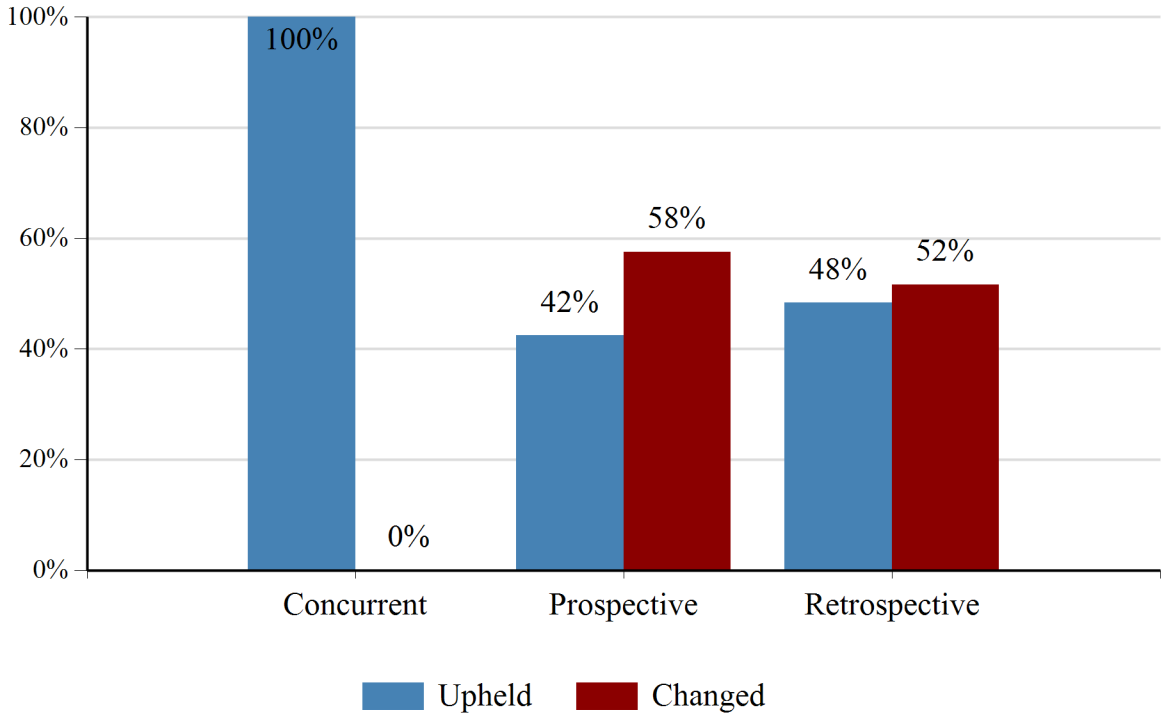
Timing of Denials

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 2019. Eligibility disputes are treated as prospective denials.



Outcomes by Timing of Denials

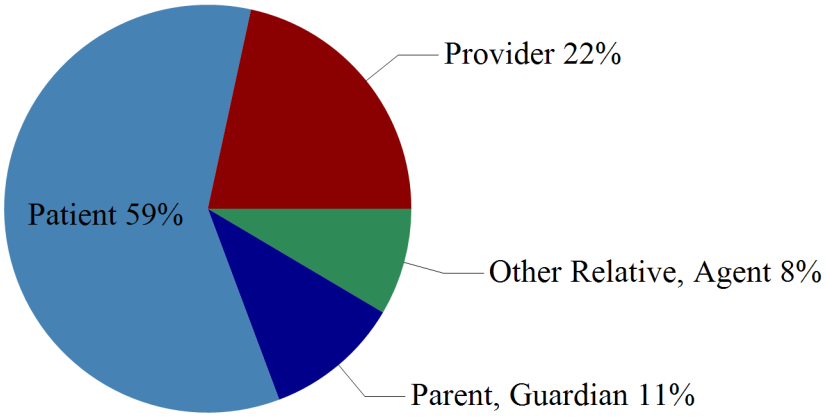
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2019 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

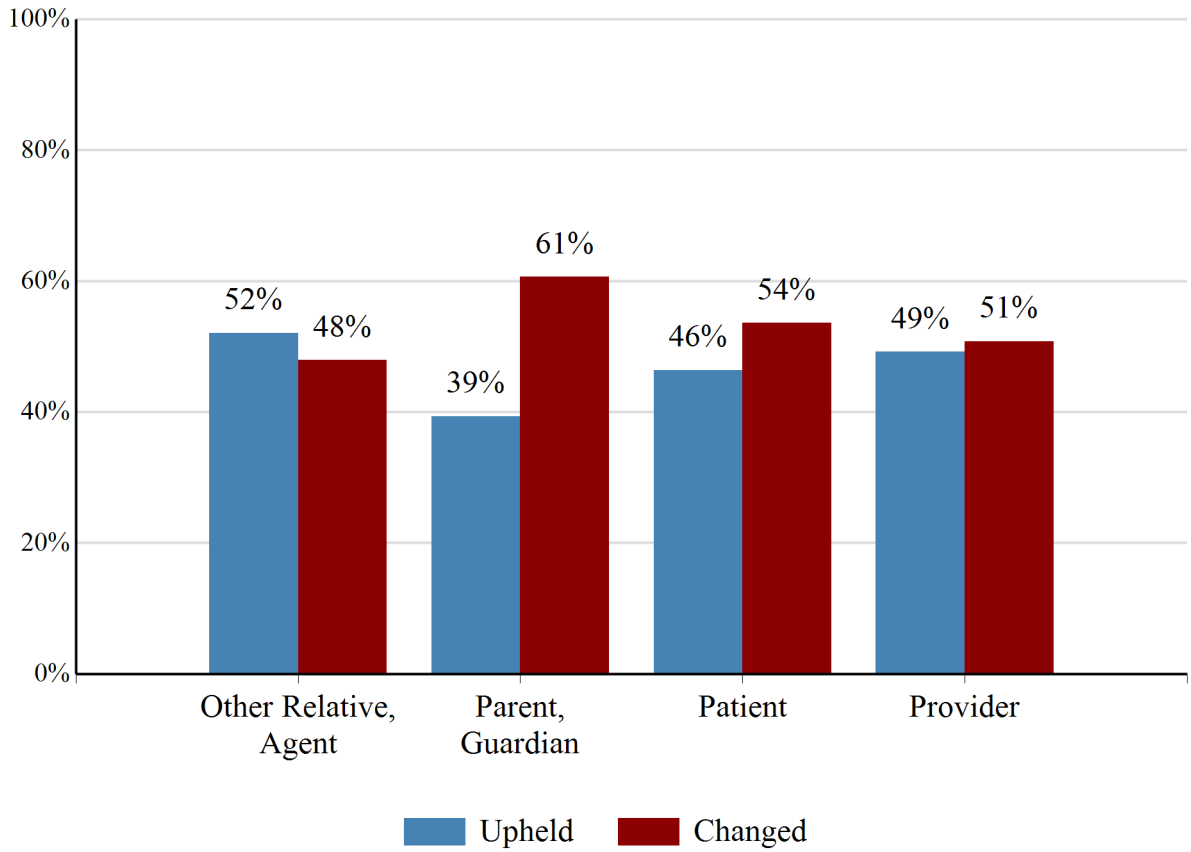
Who Filed the Case

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 2019.



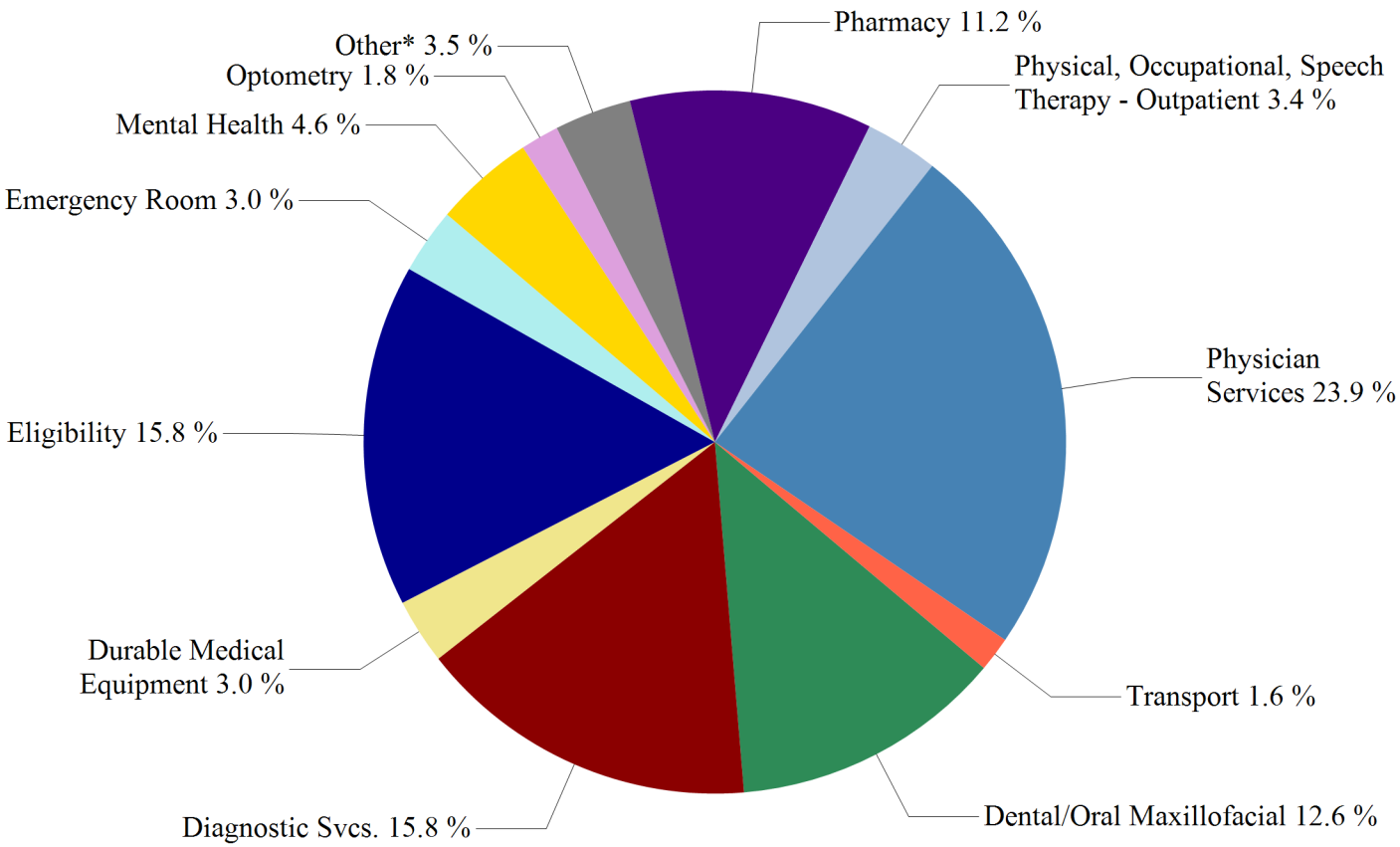
Outcomes by Who Filed the Case

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 2019.



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 2019.

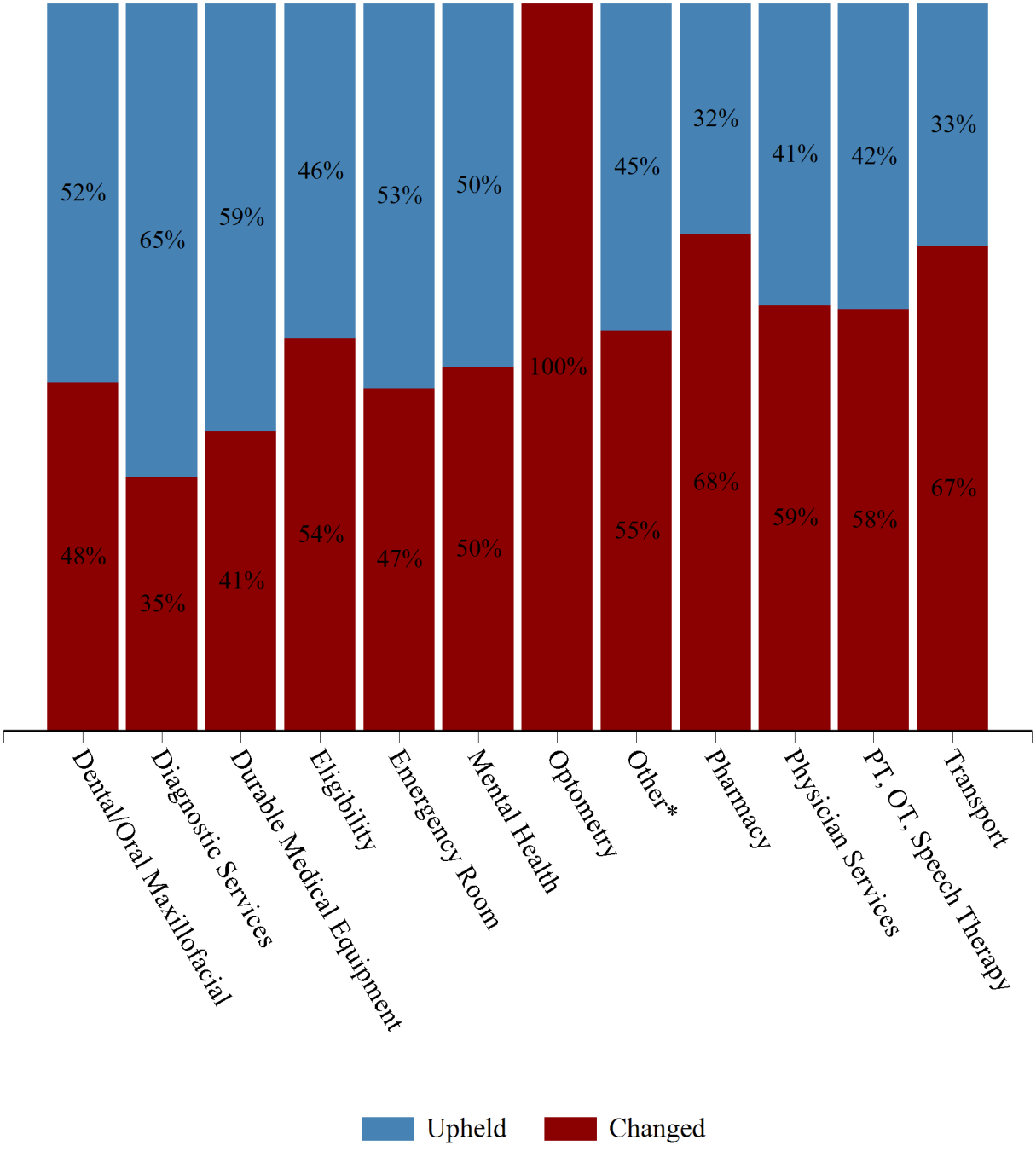


* "Other" includes habilitative services, home health, hospital length of stay, inpatient physical rehabilitation, podiatry, skilled nursing facility, substance abuse, and other non-specific categories (e.g. nutrition therapy).

Percentages may not equal 100% due to rounding.

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 2019 based on the types of services denied.



* "Other" includes habilitative services, home health, hospital length of stay, inpatient physical rehabilitation, podiatry, skilled nursing facility, substance abuse, and other non-specific categories (e.g. nutrition therapy).