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 2021, beginning July 1, 2020, and concluding June 30, 2021.

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

[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).

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[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 because carriers are not required to report membership or enrollee numbers.

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

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

Carrier Statistics FY 2021

In addition to the highlights below, statistical details from the data submitted by carriers appear in charts on pages 17-25 of this report.

1. Carriers reported 79,017 adverse decisions in FY 2021, 3,985 more adverse decisions than reported in FY 2020. Many carriers increased the number of adverse decisions issued in FY 2021 over FY 2020. Notably, in FY 2021:

    - Aetna Dental Inc. issued 12% more adverse decisions than in FY 2020;
    - Ameritas Life Insurance Corp. issued 74% more adverse decisions than in FY 2020;
    - CareFirst BlueChoice, Inc. issued 10% more adverse decisions than in FY 2020;
    - CIGNA Health and Life Insurance Company issued 68% more adverse decisions than in FY 2020;
    - Dominion Dental Services, Inc. issued 107% more adverse decisions than in FY 2020;
    - Guardian Life Insurance Company of America issued 27% more adverse decisions than in FY 2020;
    - Johns Hopkins HealthCare LLC issued 44% more adverse decisions than in FY 2020;
    - Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. issued 6% more adverse decisions than in FY 2020;
    - Metropolitan Life Insurance Company issued 51% more adverse decisions than in FY 2020;
    - Principal Life Insurance Company issued 61% more adverse decisions than in FY 2020; and
    - Sun Life Assurance Company of Canada issued 47% more adverse decisions than in FY 2020.

2. The carriers administratively reversed only 275 of the reported adverse decisions, less than 1%.

3. In FY 2021, consumers filed 7,096 grievances, challenging less than 10% of the adverse decisions.

4. Like FY 2020, the largest percentage of grievances filed were in the pharmacy (50%), dental (26%), lab/radiology (8%), and physician (6%) service categories.

5. Overall, in FY 2021, during the internal grievance process, carriers altered 57% of their original adverse decisions, overturning 52% 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 2021, carriers reported an overturned or modified rate of 23% for mental health and substance abuse services. This rate was higher than the 19% overturned or modified rate in FY 2020.

7. In FY 2021, dental decisions were overturned 49% of the time. Adverse decisions involving pharmacy claims are the most likely to be overturned as reflected in a five-year review of data: 69% in FY 2021, 63% in FY 2020, 59% in FY 2019, 60% in FY 2018, 65% in FY 2017, and 71% in FY 2016.

8. In FY 2021, inpatient hospital service decisions were overturned 45% 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 five working days of receipt

[8] 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.

of the complaint, the MIA will contact the carrier in writing requesting a written response to the complaint. Unless an extension request from the carrier is granted by the MIA, the carrier shall respond to the MIA within seven working days of receipt of the complaint (with the exception of a complaint that involves an emergency issue that must be resolved within 24 hours of receipt of the complaint), and the carrier must respond to the MIA by providing medical and claims information (including the health benefit contract) pertinent to the complaint and either uphold, reverse, or modify its denial. When the MIA does not have jurisdiction over the complaint or the carrier's internal grievance process has not been exhausted, the MIA refers the complainant to the HEAU so that the member, the member's authorized representative, a health care provider or facility can be assisted through the carrier's internal grievance process or external review process as applicable.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then the MIA will prepare the case for review. As part of the preparation, the MIA will contact the complainant and the carrier in writing, giving them a deadline for submitting additional documentation to be considered in the review as applicable. Once the MIA receives the proper documentation, the case is copied and forwarded to an Independent Review Organization ("IRO") for medical necessity review. In selecting an IRO, the MIA ensures that the IRO has an appropriate board-certified physician available to review the case. Upon receipt of the case from the MIA, the IRO then transmits the case to its expert reviewer who researches and reviews the case, renders an opinion, and transmits the opinion back to the IRO. The IRO, in turn, conducts a quality review of the expert reviewer's opinion. For medical necessity reviews, the MIA asks the IRO to respond to specific questions as set forth in a cover letter attached to the complaint. The IRO will orally inform the MIA of the expert reviewer's determination and follow up with the written determination via facsimile, first-class mail, or electronic mail. If the IRO reviewer's recommendation is to overturn, uphold, or modify the carrier's denial, the MIA may accept this recommendation and base its final closing letter on the professional judgment of the IRO reviewer. The complainant may be notified in writing of the outcome by electronic mail, U.S. mail, or via facsimile. The MIA also forwards a copy of the IRO's medical opinion and invoice to the carrier via facsimile and U.S. mail. In all instances, the carrier that is the subject of the complaint must pay the expenses of the IRO selected by the MIA. Hearing rights to contest the MIA decision are given to all consumers, except for individuals covered under the State of Maryland employee/retiree plan. Carriers do not have a right to an administrative hearing but may file a petition for judicial review.

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

MIA Statistics FY 2021

MIA-provided data are reported on the charts and tables contained on pages 26-32 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 709 complaints in FY 2021. After reviewing these complaints, the MIA determined that 344 involved MIA-regulated adverse decisions.

2. The MIA referred 39 of those complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 305 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 196 cases (64%). The MIA upheld 109 (36%) of the carrier decisions.

4. Similar to FY 2020, the largest percentages of grievances filed were in the pharmacy services/formulary issues (44%); lab, imaging, and test services (15%); physician services (14%); and dental care (11%), categories.

VI. Health Education and Advocacy Unit

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

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

When the HEAU receives a request for assistance, the HEAU gathers basic information from the carriers related to the services or care denied. Specifically, the HEAU asks the carrier to provide a copy of the insurance contract provisions and the utilization review criteria upon which the carrier based the denial and to identify precisely which provisions or criteria the patient failed to meet. Carriers must provide requested information to the HEAU within seven working days from the date the carrier received the request. The HEAU also gathers information about

the patient's condition from the patient and 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.

A. HEAU Statistics FY 2021

The HEAU Appeals and Grievances data[9] are reported in the charts and tables contained on pages 33-49 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 2021.

The HEAU closed 1,642 cases in FY 2021.

1. 38% 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. 13% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection-related issues.

3. 551 of the complaints closed by the HEAU were cases involving appeals and grievances. Not all the 551 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 551 appeals and grievances cases the HEAU closed during FY 2021, 388 (70%) involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 388 cases involved more than one carrier.

4. Of the 388 appeals and grievances cases the HEAU mediated during FY 2021, 31% were adverse decision (*medical necessity*) cases, 64% were coverage decision (*contractual exclusion*) cases, and 5% were eligibility 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.

5. The HEAU mediation process resulted in 56% of the medical necessity cases, 49% of the coverage decision cases, and 65% of the eligibility denial cases being overturned or modified.

6. HEAU mediation efforts resulted in a decision change of 67% in cases involving at least one MIA-regulated plan. In cases involving non-regulated plans, the HEAU efforts resulted in a decision change 45% of the time.

7. In FY 2021, the HEAU assisted patients in recovering or saving nearly $2.8 million dollars, including nearly $2.2 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, 52% 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 29-year-old woman was involved in a scuba diving incident in Ecuador. Her injury required immediate hyperbaric treatment to prevent permanent neurological damage, so she went to the only provider within 600 miles capable of providing this treatment. She obtained initial approval from her carrier for the treatment. She received a $12,180 bill after her carrier processed the claim allowing only $1,759.13. With HEAU's involvement, the consumer's carrier agreed to increase its reimbursement to the provider and the provider agreed not to balance bill the consumer. Ultimately, the consumer was responsible for $769.73, saving the consumer $11,410.27.

2. A 12-year-old child with growth hormone deficiency was receiving daily growth hormone injections, which his insurer covered for three years. When seeking yearly pre-authorization for his fourth year of treatment, the insurance carrier denied the treatment as not medically necessary. Since human growth hormone injections are prohibitively expensive, paying out-of-pocket for this therapy was not affordable for the family. The HEAU appealed the denial internally with the carrier and the carrier upheld its denial. The HEAU submitted an external appeal, and the Independent Review Organization overturned the denial, saving the consumer $96,144.

3. A 22-year-old woman needed arthroscopic hip surgery to relieve constant pain in her hip joint. Her HMO denied the pre-authorization for an out-of-network surgeon to render this specialized surgery, claiming that the expertise was available in-network. The in-network surgeons the HMO recommended specialized in hip replacement surgery rather than arthroscopic surgery. The consumer's primary care physician submitted an internal appeal recommending the referral to the out-of-network surgeon, but the HMO upheld its denial. The HEAU prepared a second internal appeal,

challenging not only the availability of an in-network provider with the necessary surgical expertise, but also challenging the geographic proximity of in-network expertise, if any. Her HMO overturned its denial, which enabled the consumer to have arthroscopic hip surgery with the cost of the out-of-network surgeon covered by her HMO.

4. Prior to having his daughter evaluated by an out-of-network psychologist for educational purposes, the consumer called his carrier to confirm that he had out-of-network benefits and that his plan provided coverage of psychological testing for educational reasons. His carrier's representative confirmed his policy included out-of-network mental health services and covered testing for educational purposes. When he later submitted a claim for the services, his carrier denied the claim for myriad reasons, including failure to obtain pre-authorization and a lack of clinical justification. He contacted the HEAU after multiple attempts failed to have the claim covered. After the HEAU took the case, the carrier agreed to reprocess the claims once they received the child's medical records. Upon reviewing the records, the insurer denied the claims citing the plan's exclusion of coverage for psychological testing for educational reasons. At the urging of the HEAU, the carrier reviewed the transcript of the initial call made by the consumer and acknowledged that the customer service representative had given incorrect benefit information to the consumer. As a result, the carrier agreed to process the claims as a covered service under the consumer's health plan, saving the consumer $978.

5. An 18-year-old man had surgery performed for treatment of hyperhidrosis (excessive sweating). Prior to the surgery the hospital obtained preapproval from the consumer's carrier. Following the surgery, the carrier processed and approved the facility, radiology, and the surgeon's claims without incident. However, the carrier deemed that anesthesia was not covered under the member's contract. The HEAU appealed the denial. Ultimately it was determined that treatment for hyperhidrosis was an excluded benefit. Because the hospital obtained preapproval for the surgery and provided the customer service representative the hyperhidrosis diagnostic code when seeking the preapproval, the carrier agreed to reprocess and cover the anesthesiologist's claim, saving the consumer $3,900.

6. A 62-year-old consumer had been taking a brand name medication for a thyroid condition consistently since 2014. When she attempted to obtain a refill, her carrier denied coverage because the brand name drug was off-formulary and the plan required her to try and fail a generic drug first ("step therapy"). The consumer's physician provided records stating that the consumer had tried the on-formulary generic drug prior to 2014 and that it was unsuccessful in controlling her TSH level. The carrier continued to deny coverage. The HEAU sought external review resulting in the carrier overturning the denial and approving the medication for one year.

7. A 35-year-old Maryland resident suffered from psoriatic arthritis. After trying several medications without success, he was prescribed Enbrel which significantly improved his health. When he switched jobs and employer-based insurance, his new carrier denied coverage of Enbrel because it was off-formulary and required step-therapy. The

consumer unsuccessfully appealed the denial twice with the carrier. The carrier's plan documents were unclear suggesting on the one hand that step therapy was required, but also suggesting that continuation of Enbrel therapy required proof of a positive clinical response. The HEAU obtained his medical records and appealed the denial, resulting in the carrier overturning the denial and approving the medication for one year.

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 the decisions may be warranted, especially when having to pursue the appeals and grievance process presents inherent health or safety risks to a patient.

C. Additional HEAU Activities and Data

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

In FY 2021, the greatest percentage of non-appeals related cases were in the following categories.

- Billing - Billed for Services Not Performed
- Billing - Consumer Seeks Itemized Bill or Clarification of Charges
- Billing - Patient Feels that Charges are Too High
- Enrollment - APTC/CSR Dispute
- COVID-19 - PPE Fee
- Billing - Failure to Refund Overpayment
- Medical Records - Patient Requesting Copies of Medical Records
- Billing - Billed for Charges Already Paid
- COVID-19 Testing

The HEAU continues to monitor and offer consumer-centric input to State agencies involved in health policy decision making. 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 Maryland Easy Enrollment Workgroup; the General Assembly's Health Insurance Consumer Protections Workgroup; the Maryland Health Care Commission's Health Information Exchange Advisory Workgroup; and the Maryland Health Care Commission's Surgical Services 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), opposing efforts to defund Planned Parenthood, opposing efforts to eliminate anti-discrimination protections, opposing efforts to limit access to reproductive rights, and supporting efforts to prevent sham employer health plans. In addition, the HEAU worked with the Office and others to

comment on federal and state regulations and other policies to enhance consumer protections in the health care marketplace.

D. Areas of Concern

1. Surprise Billing and the No Surprises Act

For years the HEAU has reported about consumers receiving surprise bills. Surprise medical bills occur when consumers are unknowingly treated by out-of-network providers due to no fault of their own, or despite their best efforts to seek care in-network. Even consumers who do their very best to make sure their care will be provided in-network later receive balance bills from providers they did not think to check on like assistant surgeons, anesthesiologists, and radiologists or for ancillary service providers like laboratories. Consumers understandably are exasperated when they receive surprise bills from out-of-network hospital-based providers they were not told about and did not choose. The bills are often very high and arise out of disruptive emergencies, e.g., $36,000 for neonatology services provided to a newborn infant.

The recently enacted federal No Surprises Act (Title I of Division BB of the Consolidated Appropriations Act, 2021) establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items/services beginning on January 1, 2022.

The HEAU looks forward to working with all stakeholders to implement this law in Maryland and to ensure enforcement of its provisions for the benefit of Maryland consumers.

2. COVID-19 Surcharges

As reported in our FY 2020 Annual Report, shortly after the resumption of elective medical procedures, the HEAU received complaints from consumers about health care providers, largely dentists, charging consumers, at the point-of-service, personal protective equipment ("PPE")/infection control fees ranging from $10-$40. Our office immediately reached out to the state medical and dental associations, and later issued a press release notifying providers that:

- To the extent patients were insured and seeking care from a participating provider, applicable insurance contracts likely prohibited patient billing because PPE/infection control are integral components of any covered service.
- The fees are prohibited by Medicare and Medicaid.
- To the extent patient billing is permissible, any such fees must be disclosed in advance.

Despite our outreach efforts, the HEAU continued to receive complaints from insured consumers being charged PPE fees for otherwise covered services. Through continued mediation efforts, we have halted the collection and sought refunds for improperly collected fees from more than 60 providers.

3. COVID-19 Testing Costs and Coverage

As also reported in our FY 2020 Annual Report, early in the public health emergency, the HEAU received complaints from consumers about healthcare providers, largely urgent care

centers, billing patients at the point-of-service for diagnostic COVID-19 testing in violation of federal and state laws. Our office immediately reached out to the state medical associations, and later issued a press release notifying providers and consumers that billing patients for testing in violation of state and federal laws was also a violation of the Consumer Protection Act. Through mediation efforts, we have halted the collection of and obtained refunds for improperly collected fees. One urgent care center refunded $3,405 to 81 patients.

The HEAU nevertheless has received numerous complaints about urgent care centers (and their licensed employees), and other COVID-testing providers that continue to raise concerns of legal noncompliance. The Maryland State of Emergency terminated August 15, 2021, but the federal State of Emergency and the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) remain in effect, including the testing provisions. On February 26, 2021, CMS issued guidance about testing to clear up confusion created by 2020 guidance purporting to narrow the FFCRA's mandated coverage.[10] The 2021 guidance inclusively defines "diagnostic testing" to cover individuals with or without symptoms or known or suspected exposures; creates a presumption that an individual's testing is primarily intended for diagnosis; and reaffirms that carriers must cover diagnostic testing and related services without cost sharing, prior authorization, or other medical management requirements imposed by the plan or issuer. The FFCRA and the CARES Act do not require coverage of testing for groups of asymptomatic employees or individuals with no known or suspected recent exposure to COVID-19, such as for public health surveillance or employment purposes.

Notwithstanding the clarifying guidance, multiple urgent care centers and their licensed employees require evaluation and management (E/M) visits for every test of every consumer, including asymptomatic consumers; do not code the E/M visits using the COVID-19 testing code; seemingly upcode to Level 3 or Level 4 E/M visits; and charge upfront or later bill for tests or visits that should be free for the consumer.

4. Required Prepayment of Deductibles and Coinsurance and Failure to Refund Overpayments

The HEAU is aware that many healthcare providers, including several radiology practices managed by the same management company are requiring consumers to prepay estimated deductible or coinsurance amounts before the provider will render services. It is likely that preservice collection of amounts other than known copayments from insured consumers seeking care from participating providers is impermissible under typical carrier/provider contracts.

Many consumers who prepaid later learn when they receive their carrier EOBs that they had overpaid the provider. These same consumers complain to the HEAU after the providers failed to refund overpayments in the first instance, and despite requests for a refund.

[10] *Biden Administration Strengthens Requirements that Plans and Issuers Cover COVID-19 Diagnostic Testing Without Cost Sharing and Ensures Providers are Reimbursed for Administering COVID-19 Vaccines to Uninsured,* https://www.cms.gov/newsroom/press-releases/biden-administration-strengthens-requirements-plans-and-issuers-cover-covid-19-diagnostic-testing.

5. Medical Records

a. Costs

We frequently receive hotline calls, emails and complaints from providers and consumers who describe the current Health-General provisions and corresponding regulations, particularly those related to medical records costs, as confusing and inconsistent with HIPAA. We also continue to receive complaints from consumers unable to access copies of their records because of the high costs imposed by providers. The HEAU would support legislation to clarify current Maryland law and to conform it to HIPAA, and to reduce the costs to consumers to obtain their records.

b. Electronic Health Record Errors

Consumers also have complained about patient safety issues related to electronic health record (EHR) systems. One consumer's EHR contained numerous records for a different patient with the same name and birthdate. Another consumer's MCO ID # was repeatedly used by a consumer with the same name, whose records were added into his EHR. A third consumer with numerous food, drug and other allergies has been unable to change her emergency contact information, putting her at risk if she is unconscious and unable to inform providers about her allergies and her emergency contact is not able to speak on her behalf. Hospital staff and leadership tell the consumers their EHR problems have been fixed, but the problems recur and persist. This suggests there are systemic defects making the systems default back to incorrect information or functions, raising patient safety issues. In additional to the technical defects, the HEAU is concerned about the patient identity verification problems as two of the examples stem from similar names and dates of birth. Also concerning is that such systems do not allow patients to make additions or corrections to their medical records, as is their right under Maryland law, and that providers aren't adequately addressing the problems when brought to their attention. We are referring these complaints to the Office of Health Care Quality for investigation and enforcement of the hospitals' duty to properly maintain medical records.

c. Abandoned Medical Records

The HEAU is receiving an increasing number of abandoned medical record complaints and expects the numbers will increase as more healthcare offices close. During FY 2020, a dental provider surrendered his license in the face of board disciplinary proceedings and left all his patient records behind with no way for patients to access them. After the Board of Dental Examiners refused to assist with taking possession of the records, our office was forced to obtain a court order requiring the dentist to resume control of the records and notify patients about how to obtain them. In another matter, several years ago, our office was forced to seek a court order to appoint the office as a receiver of records abandoned by a physician. Landlords frequently reach out to our office to take possession of records we do not have the legal authority to possess or the resources to handle, forcing us to seek judicial approval and do the best we can for consumers.

The HEAU has also received complaints about medical practices owned by non-physicians purchasing other medical practices and abandoning medical records with impunity because the Board of Physicians cannot discipline a non-physician. Pediatric records serially abandoned over

the last four years by a non-physician purchaser have generated five complaints on behalf of children whose records still have not been found. Some of the purchaser's records had been retrieved from a storage unit shortly before the contents were auctioned off due to non-payment of rent; others were retrieved from an office building as part of an eviction. The HEAU would support legislation to close current regulatory gaps that place pediatric and other records at risk.

6. Assisted Living Facility Resident Agreements

The HEAU successfully mediated a complaint filed by a consumer who was being pursued by debt collectors for $43,754 allegedly due under an assisted living facility resident agreement between a dementia care facility and the consumer's mother. The consumer signed the agreement on her mother's behalf as her Power of Attorney because her mother was no longer legally competent. She did not agree to pay for her mother's care using her personal funds after her mother's funds were used up. While the dementia care facility eventually waived the outstanding balance, the HEAU has concluded that better protections like those required in nursing home contracts are needed for consumers entering into assisted living facility resident agreements and would support such legislation.

VII. 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

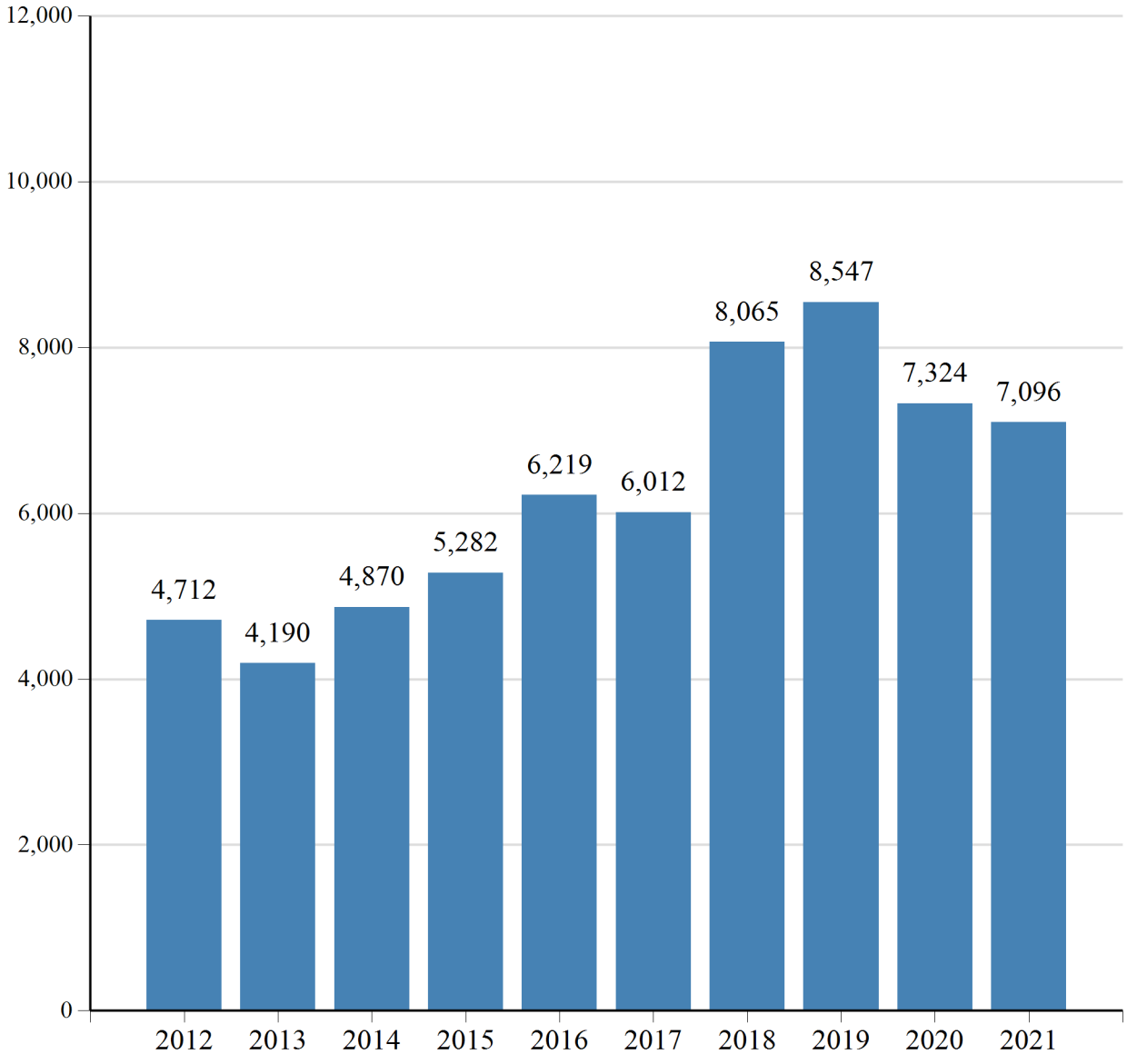
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
4 Ever Life Insurance Company	1	0	13	23%	77%
Aetna Dental Inc.	636	0	0	0%	0%
Aetna Health Inc. (a Pennsylvania corporation)	102	25	209	52%	48%
Aetna Life Insurance Company	139	26	124	60%	40%
Alpha Dental Programs, Inc.	0	0	74	36%	64%
Ameritas Life Insurance Corp.	293	0	119	62%	38%
CareFirst BlueChoice, Inc.	20,926	0	1,686	39%	61%
Carefirst of Maryland, Inc.	7,310	0	865	30%	70%
CIGNA Dental Health of Maryland, Inc.	18	0	0	0%	0%
CIGNA Health and Life Insurance Company	14,393	119	478	50%	50%
Combined Insurance Company of America	0	0	7	29%	71%
Connecticut General Life Insurance Company	11	0	0	0%	0%
Delta Dental Insurance Company	13	0	43	56%	44%
Delta Dental of Pennsylvania	25	0	310	70%	30%
Dental Network, Inc.	6	3	1	100%	0%
Dentegra Insurance Company	2	0	4	75%	25%
Dominion Dental Services, Inc.	1,106	1	86	37%	63%
Golden Rule Insurance Company	12	0	3	67%	33%
Group Dental Service of Maryland, Inc.	3,013	0	1	100%	0%
Group Hospitalization and Medical Services, Inc.	5,460	0	770	35%	65%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Guardian Life Insurance Company of America	946	1	498	60%	40%
Johns Hopkins HealthCare LLC	104	0	47	60%	40%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	725	0	77	75%	25%
Kaiser Permanente Insurance Company	57	0	5	40%	60%
Lincoln Life & Annuity Company of New York	3	1	0	0%	0%
Lincoln National Life Insurance Company	118	41	0	0%	0%
MAMSI Life and Health Insurance Company	1,093	0	109	50%	50%
Metropolitan Life Insurance Company	689	53	24	79%	21%
National Health Insurance Company	9	0	2	100%	0%
Optimum Choice, Inc.	2,551	0	155	37%	63%
Principal Life Insurance Company	656	0	7	86%	14%
Reliance Standard Life Insurance Company	13	0	3	33%	67%
Securian Life Insurance Company	0	0	5	80%	20%
Standard Insurance Company	77	0	10	70%	30%
Standard Security Life Insurance Company of New York	0	0	1	0%	100%
Starmount Life Insurance Company	18	1	18	72%	28%
Sun Life Assurance Company of Canada	674	0	24	38%	63%
Unicare Life & Health Insurance Company	1	0	0	0%	0%
United Concordia Dental Plans, Inc.	5	0	1	100%	0%
United Concordia Insurance Company	748	0	297	27%	73%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
United of Omaha Life Insurance Company	72	4	34	29%	71%
UnitedHealthcare Insurance Company	15,583	0	877	44%	56%
UnitedHealthcare of the Mid-Atlantic, Inc.	1,294	0	53	34%	66%
Wellfleet Group LLC	113	0	55	33%	67%
Wellfleet Insurance Company	2	0	1	0%	100%
Totals	**79,017**	**275**	**7,096**	**43%**	**57%**

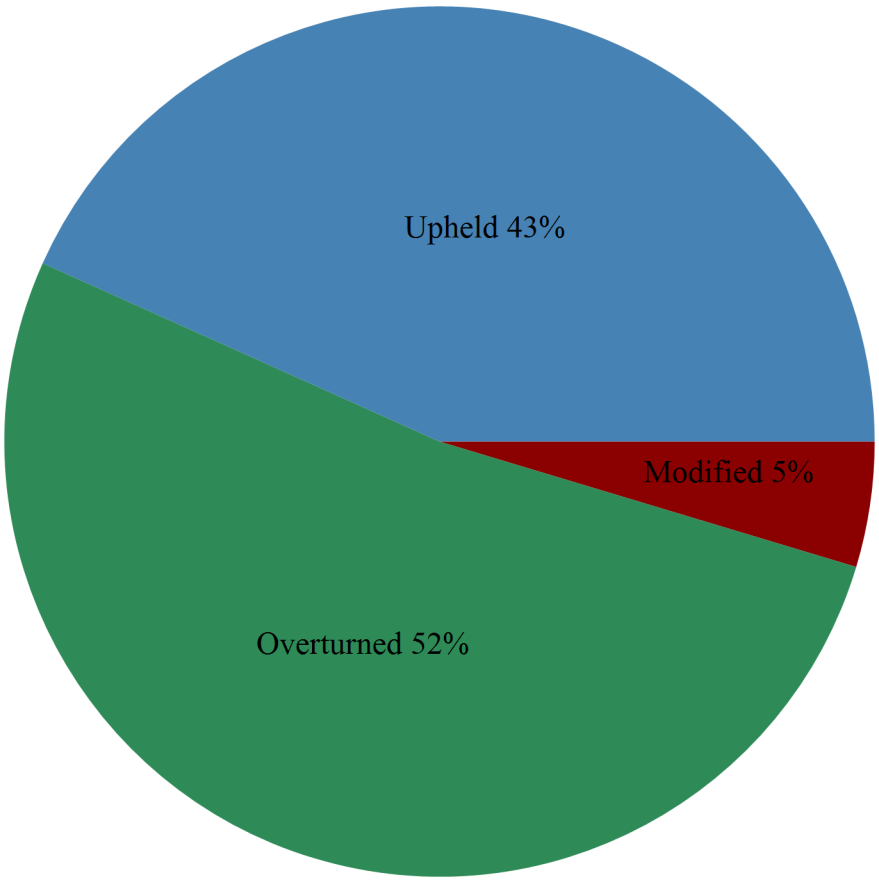
Carrier Grievances Cases
Number of Grievances Since Fiscal Year 2012

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.



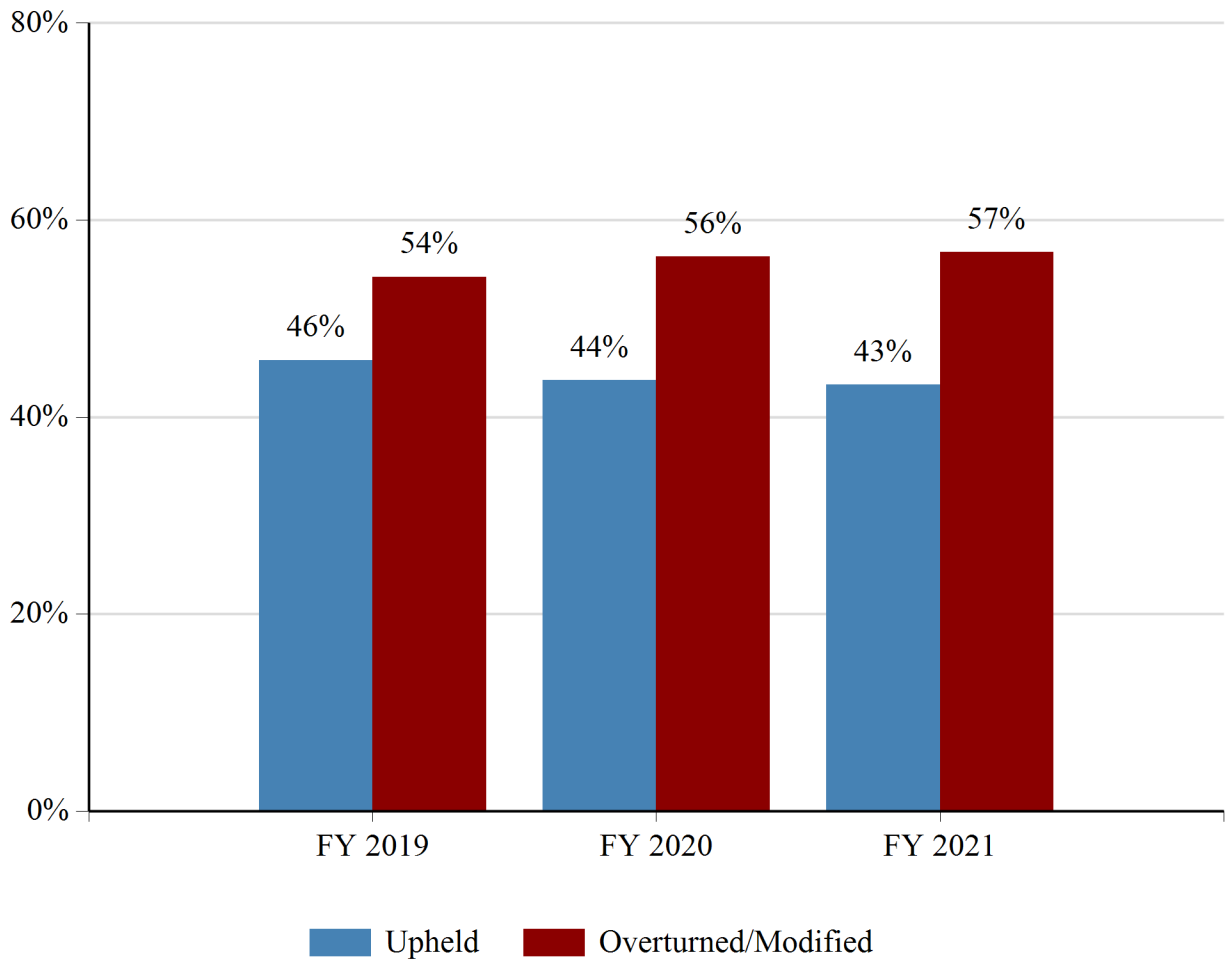
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 7,096 internal grievances filed with carriers in FY 2021, 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 2021, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	16,596	21.003%	1,880	26.494%
Durable Medical Equipment	1,336	1.691%	175	2.466%
Emergency Room	14	0.018%	22	0.310%
Home Health	155	0.196%	1	0.014%
Inpatient Hospital	1,060	1.341%	110	1.550%
Laboratory, Radiology	12,887	16.309%	582	8.202%
Mental Health / Substance Abuse	644	0.815%	87	1.226%
Other*	692	0.876%	223	3.143%
Pharmacy	37,885	47.945%	3,518	49.577%
Physician	4,018	5.085%	415	5.848%
PT, OT, ST, including inpatient rehabilitation	3,701	4.684%	76	1.071%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	29	0.037%	7	0.099%
Totals	**79,017**	**100%**	**7,096**	**100%**

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

Carrier Grievances Cases
Outcomes by Service Type

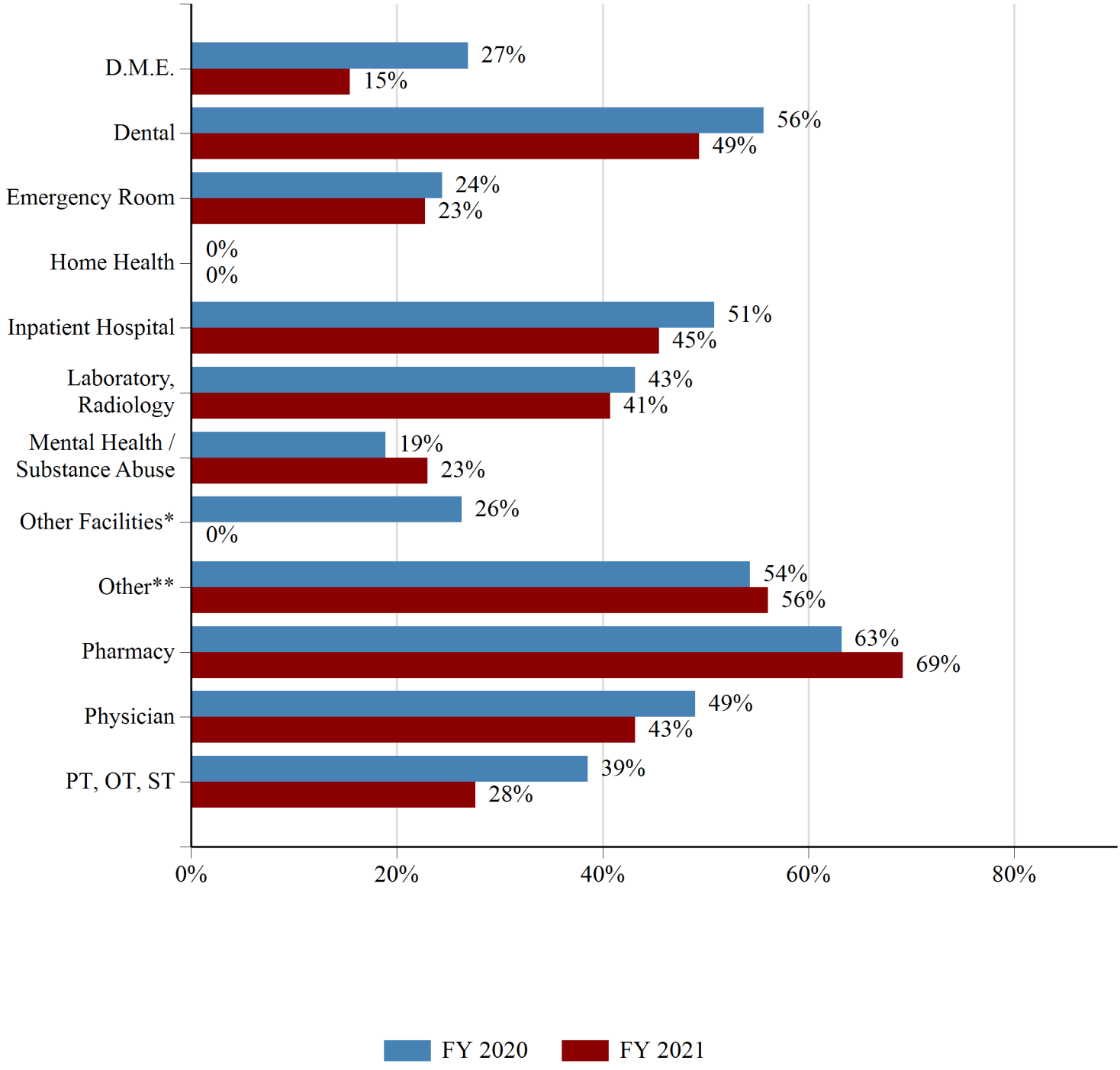
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Dental	1,880	51%	49%
Durable Medical Equipment	175	85%	15%
Emergency Room	22	77%	23%
Home Health	1	100%	0%
Inpatient Hospital	110	55%	45%
Laboratory, Radiology	582	59%	41%
Mental Health / Substance Abuse	87	77%	23%
Other*	223	44%	56%
Pharmacy	3,518	31%	69%
Physician	415	57%	43%
PT, OT, ST, including inpatient rehabilitation	76	72%	28%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	7	100%	0%
Totals	**7,096**	**43%**	**57%**

*"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 2020 and FY 2021.

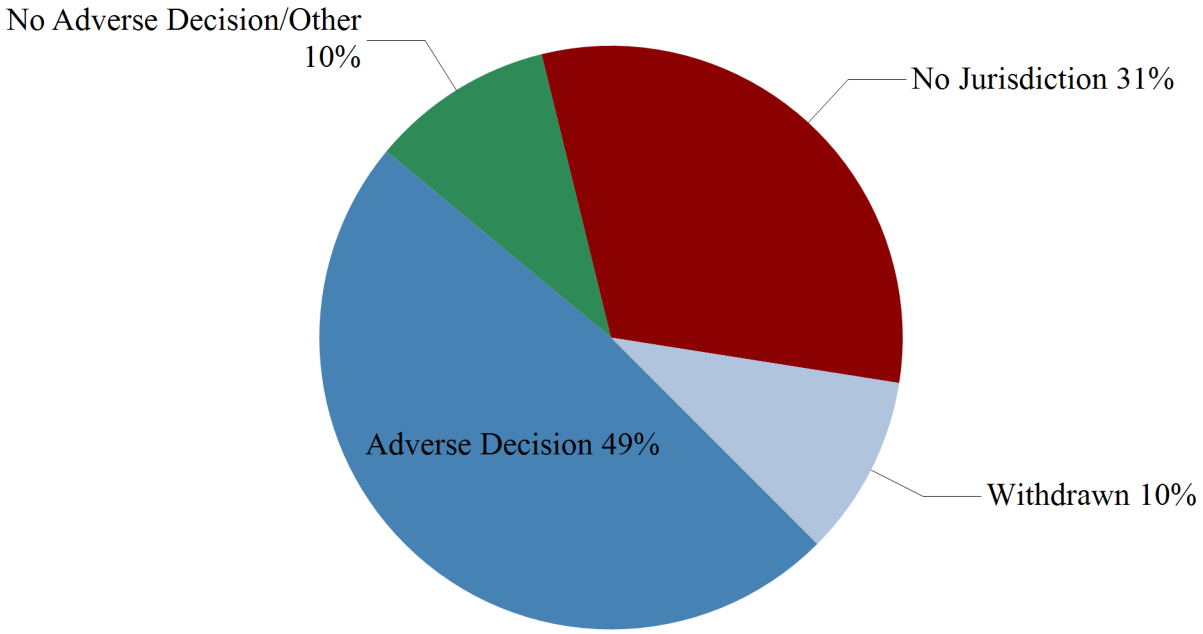


* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.
** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints
Initial Review of Cases

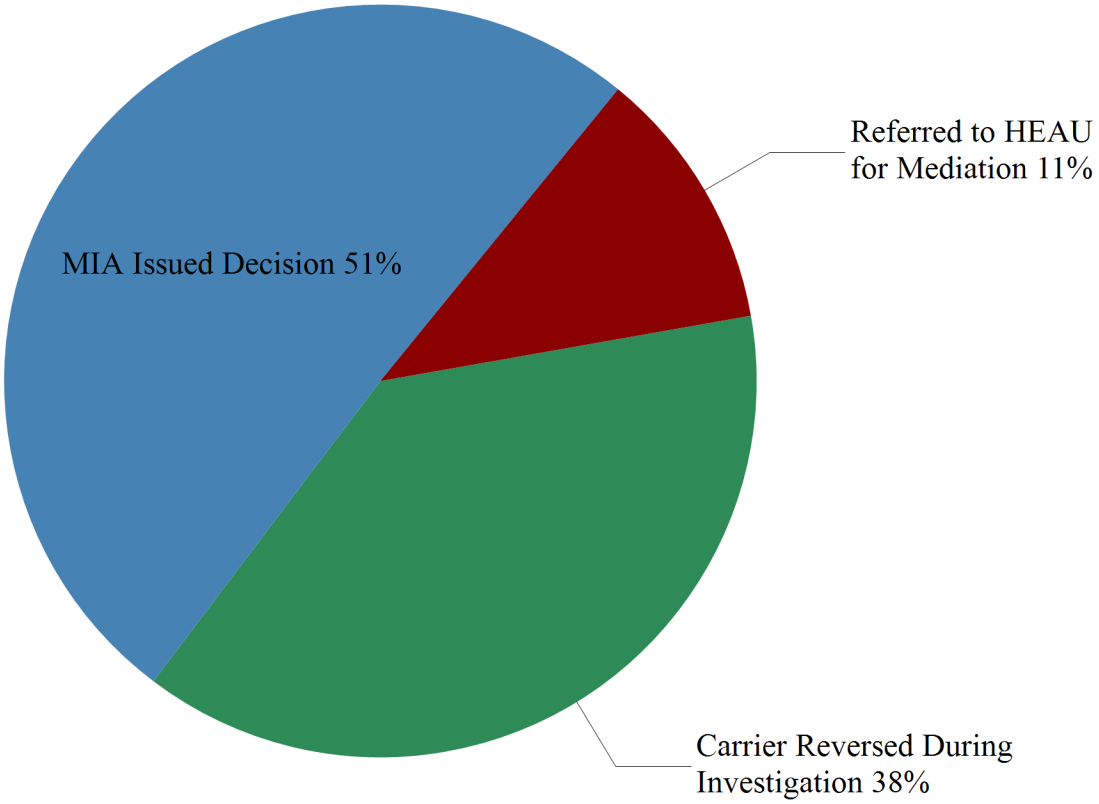
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some 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 709 cases filed with the MIA's Appeals and Grievances Unit during FY 2021.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2021, the MIA determined that 344 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 39 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 344 grievances the MIA reviewed during FY 2021.



MIA Appeals and Grievances Cases
Carriers and Disposition

The table below details the outcomes of the 305 grievances complaints the MIA investigated during FY 2021. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

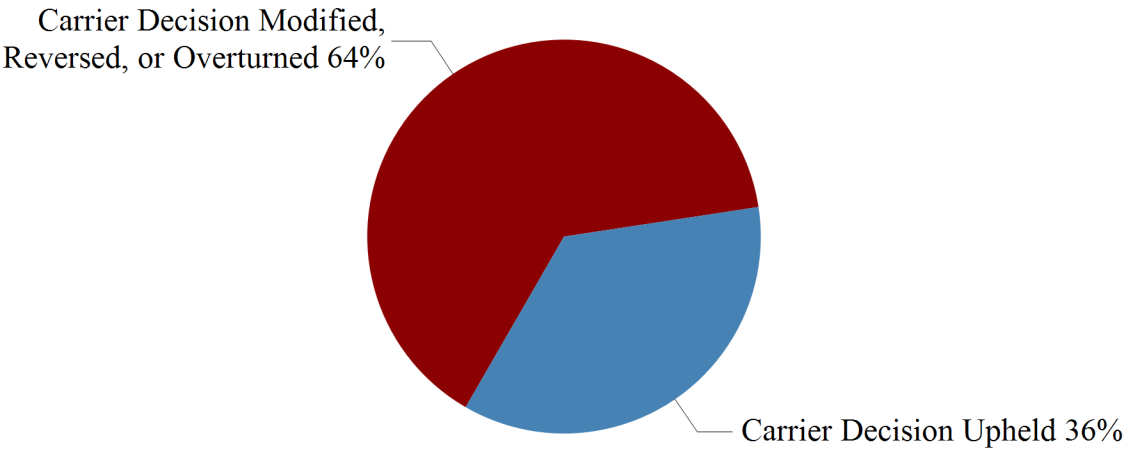
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	8	4	50.0%	0	0.0%	0	0.0%	4	50.0%
Aetna Life Insurance Company	1	0	0.0%	1	100.0%	0	0.0%	0	0.0%
CareFirst BlueChoice, Inc.	67	27	40.3%	14	20.9%	0	0.0%	26	38.8%
Carefirst of Maryland, Inc.	71	26	36.6%	16	22.5%	1	1.4%	28	39.4%
CaremarkPCS Health L.L.C.	6	1	16.7%	0	0.0%	0	0.0%	5	83.3%
CIGNA Health and Life Insurance Company	18	7	38.9%	6	33.3%	0	0.0%	5	27.8%
Delta Dental Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Dominion Dental Services, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Express Scripts Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Group Hospitalization and Medical Services, Inc.	11	7	63.6%	0	0.0%	0	0.0%	4	36.4%
Guardian Life Insurance Company of America	9	2	22.2%	1	11.1%	0	0.0%	6	66.7%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	18	6	33.3%	5	27.8%	0	0.0%	7	38.9%
MAMSI Life and Health Insurance Company	6	2	33.3%	2	33.3%	0	0.0%	2	33.3%
Metropolitan Life Insurance Company	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
Optimum Choice, Inc.	5	0	0.0%	1	20.0%	0	0.0%	4	80.0%
Principal Life Insurance Company	1	0	0.0%	1	100.0%	0	0.0%	0	0.0%

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
United Concordia Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
United Concordia Life and Health Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
UnitedHealthcare Insurance Company	74	25	33.8%	16	21.6%	1	1.4%	32	43.2%
UnitedHealthcare of the Mid-Atlantic, Inc.	3	1	33.3%	0	0.0%	0	0.0%	2	66.7%
Totals	**305**	**109**	**36%**	**63**	**21%**	**2**	**1%**	**131**	**43%**

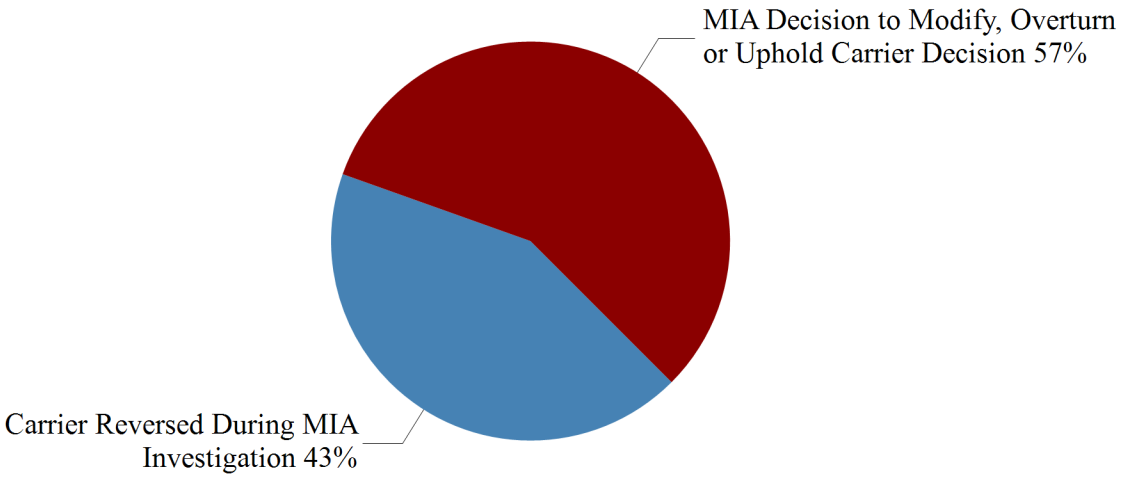
Percentages may not equal 100% due to rounding.

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 305 grievances the MIA investigated during FY 2021.

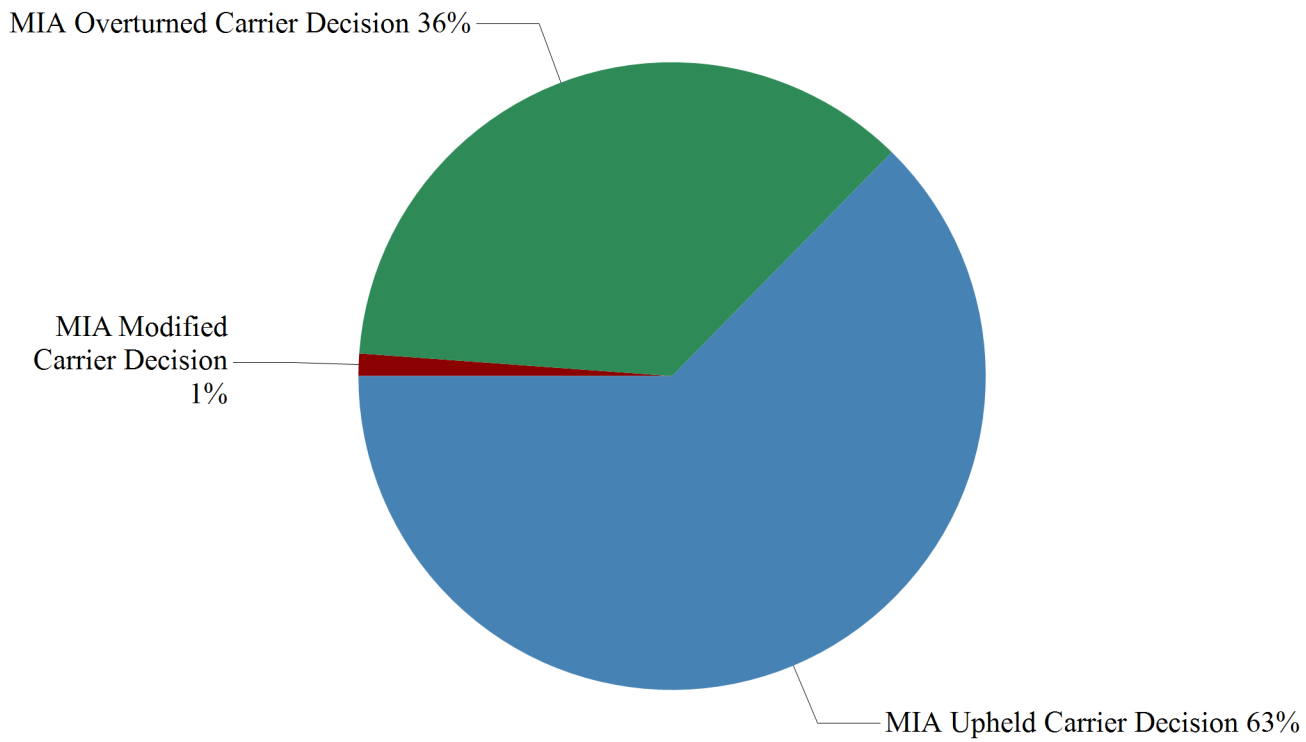


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 174 cases the MIA forwarded to an IRO for review in FY 2021.



MIA Appeals and Grievances Cases
Types of Services Denied and Outcomes

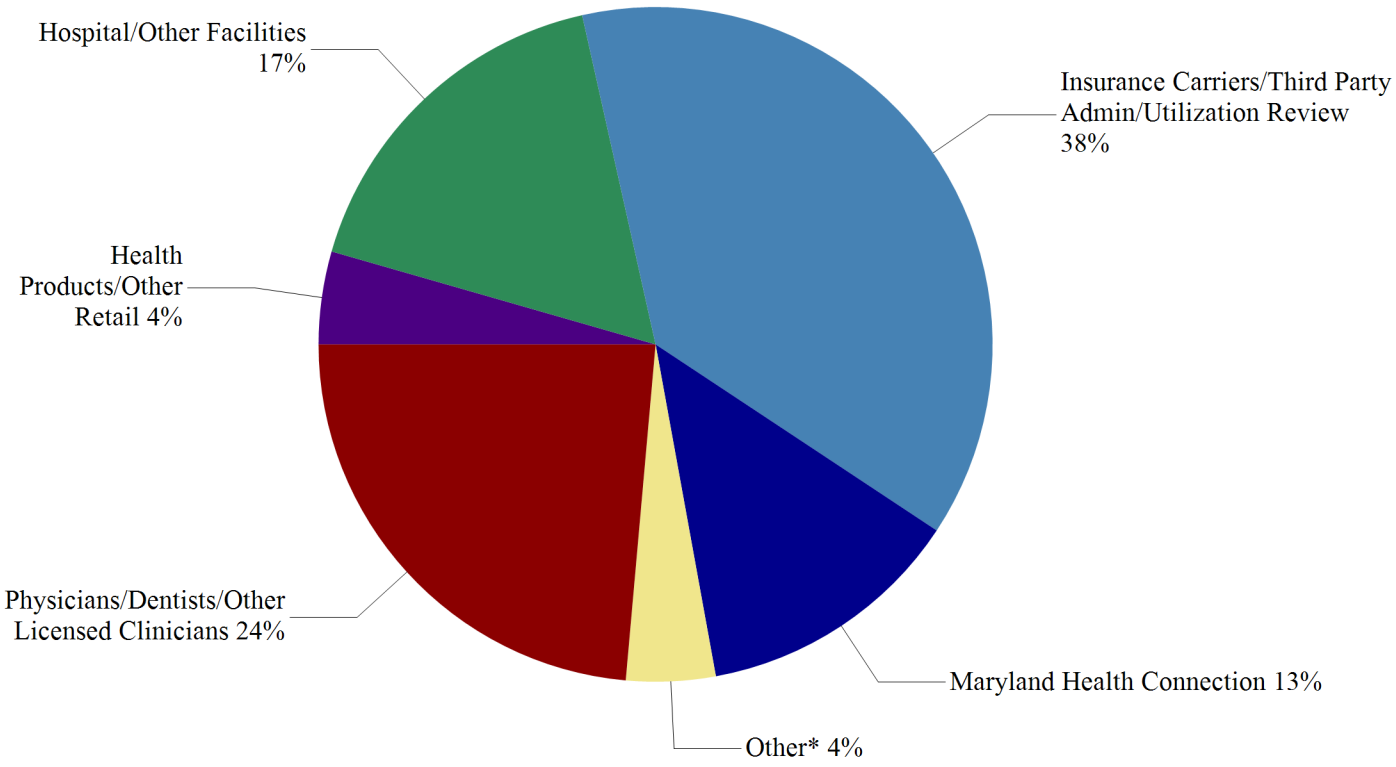
The table below identifies the types of services involved in grievances the MIA investigated during FY 2021. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Air Ambulance	1	<1 %	1	100%	0	0%	0	0%	0	0%
Cosmetic	3	<1 %	0	0%	2	67%	1	33%	0	0%
Dental Care Services	35	11%	12	34%	5	14%	0	0%	18	51%
Durable Medical Equipment	8	3%	2	25%	3	38%	0	0%	3	38%
Experimental	7	2%	4	57%	3	43%	0	0%	0	0%
In-Patient Rehabilitation Services	5	2%	2	40%	2	40%	0	0%	1	20%
Lab, Imaging, Test Services	45	15%	29	64%	7	16%	0	0%	9	20%
Laboratory Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Mental Health Partial Hospitalization	1	<1 %	0	0%	0	0%	0	0%	1	100%
Mental Health/Substance Abuse (Inpatient) Services	11	4%	4	36%	4	36%	0	0%	3	27%
Mental Health/Substance Abuse (Outpatient) Services	3	<1 %	2	67%	1	33%	0	0%	0	0%
Opioid Use Disorders	1	<1 %	0	0%	0	0%	0	0%	1	100%
PCP Referrals	1	<1 %	0	0%	0	0%	0	0%	1	100%
Pharmacy Services/Formulary Issues	135	44%	33	24%	25	19%	0	0%	77	57%
Physician Services	44	14%	18	41%	9	20%	1	2%	16	36%
PT, OT, ST Services	3	<1 %	1	33%	2	67%	0	0%	0	0%
Skilled Nursing Facility Care Services	1	<1 %	1	100%	0	0%	0	0%	0	0%
Totals	**305**	**100%**	**109**	**36%**	**63**	**21%**	**2**	**1%**	**131**	**43%**

Percentages may not equal 100% due to rounding.

HEAU Cases
Subject of Complaints

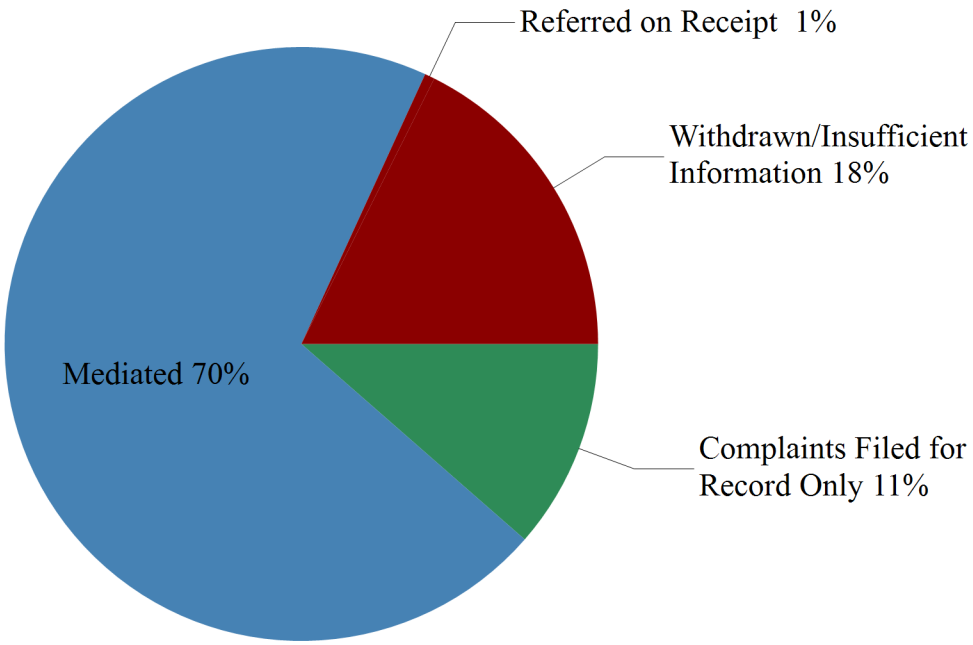
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, 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 2021. The HEAU closed 1,642 complaints. Some complaints were filed against more than one industry.



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

HEAU Appeals and Grievances Cases
Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Some consumers, or other persons, file complaints but never complete an authorization to release medical records, a form required by the HEAU to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. The chart below details the initial disposition of the 551 Appeals and Grievances cases closed by the HEAU during FY 2021.



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 2021. "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 388 cases in FY 2021. Maryland Health Connection is listed as a carrier in cases where the appeal or grievance involved a dispute that required both the carrier and Maryland Health Connection to act to resolve the dispute.

Carrier	Total Cases	Upheld		Overturned/Modified	
Aetna Health Inc.					
State Regulated	6	3	50%	3	50%
Not State Regulated	29	13	45%	16	55%
Total Complaints	**35**	**16**	**46%**	**19**	**54%**
AIM Specialty Health					
State Regulated	1	1	100%	0	0%
Not State Regulated	3	2	67%	1	33%
Total Complaints	**4**	**3**	**75%**	**1**	**25%**
Allegiance					
Not State Regulated	3	2	67%	1	33%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Alliance For Shared Health					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Alteon Health					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Anthem Blue Cross and Blue Shield					
Not State Regulated	7	6	86%	1	14%
Total Complaints	**7**	**6**	**86%**	**1**	**14%**
Anthem Blue Cross Blue Shield of Indiana					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Anthem UM Services, Inc.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Associated Administrators					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Blue Cross BlueShield of Texas					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
BlueCross BlueShield of Illinois					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
BlueCross BlueShield of North Carolina					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
BlueShield of Northeastern New York					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
CareFirst					
State Regulated	45	15	33%	30	67%
Not State Regulated	49	26	53%	23	47%
Total Complaints	**94**	**41**	**44%**	**53**	**56%**
CareFirst Administrators					
Not State Regulated	7	6	86%	1	14%
Total Complaints	**7**	**6**	**86%**	**1**	**14%**
CareFirst the Dental Network					
State Regulated	7	1	14%	6	86%
Not State Regulated	3	0	0%	3	100%
Total Complaints	**10**	**1**	**10%**	**9**	**90%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Christian Brothers Services					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CIGNA					
State Regulated	6	2	33.3%	4	66.7%
Not State Regulated	30	22	73%	8	27%
Total Complaints	**36**	**24**	**67%**	**12**	**33%**
Cigna Dental					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
CVS Caremark					
State Regulated	4	1	25%	3	75%
Not State Regulated	9	2	22%	7	78%
Total Complaints	**13**	**3**	**23%**	**10**	**77%**
Delta Dental					
State Regulated	2	0	0%	2	100%
Not State Regulated	6	4	67%	2	33%
Total Complaints	**8**	**4**	**50%**	**4**	**50%**
Delta Dental of Illinois					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Denex Dental					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Discovery Benefits, LLC					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Dominion National					
State Regulated	3	0	0%	3	100%
Not State Regulated	1	0	0%	1	100%
Total Complaints	**4**	**0**	**0%**	**4**	**100%**
Empire Blue Cross Blue Shield					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
eviCore Healthcare					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Express Scripts					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
FCE Benefits Administrators					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Freedom Life Insurance Company of America					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Golden Rule Insurance					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Government Employees Health Association (GEHA)					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Guardian Life insurance Company of America					
State Regulated	4	0	0%	4	100%
Not State Regulated	4	2	50%	2	50%
Total Complaints	**8**	**2**	**25%**	**6**	**75%**

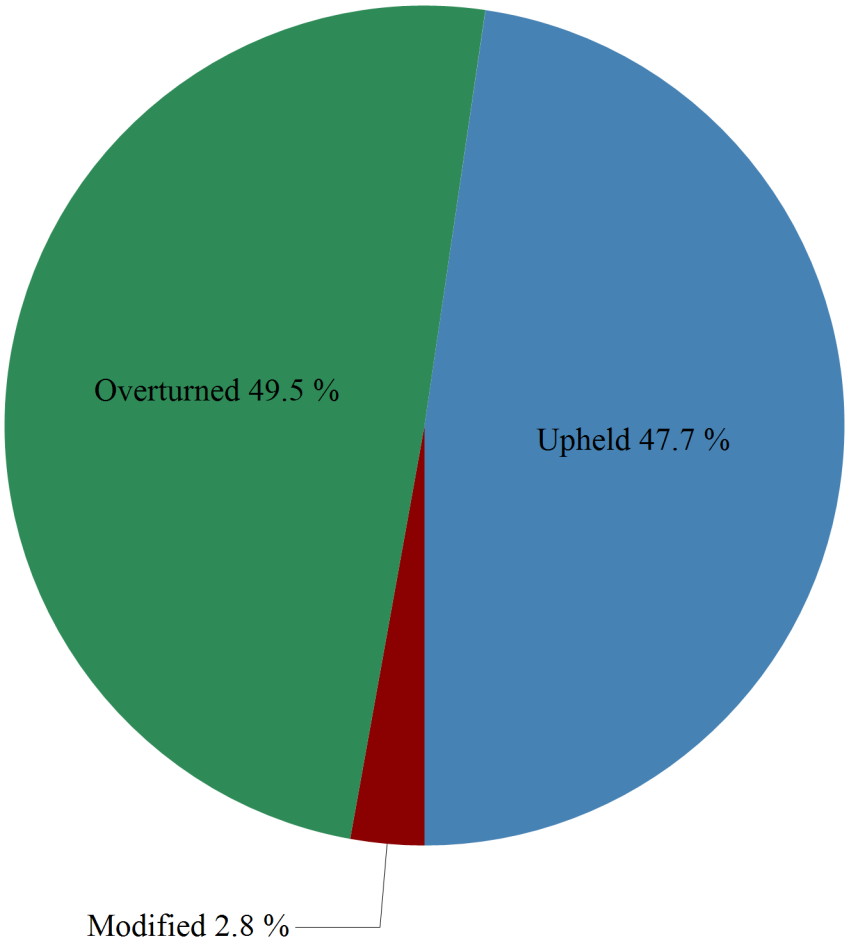
Carrier	Total Cases	Upheld		Overturned/Modified	
Highmark					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Humana					
Not State Regulated	3	1	33%	2	67%
Total Complaints	**3**	**1**	**33%**	**2**	**67%**
Johns Hopkins Advantage MD					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Johns Hopkins Employer Health Programs					
State Regulated	1	0	0%	1	100%
Not State Regulated	3	2	67%	1	33%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**
Kaiser Permanente of Colorado					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	10	4	40%	6	60%
Not State Regulated	6	4	67%	2	33%
Total Complaints	**16**	**8**	**50%**	**8**	**50%**
Maryland Health Connection					
State Regulated	4	1	25%	3	75%
Total Complaints	**4**	**1**	**25%**	**3**	**75%**
Meritain Health					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Metropolitan Life Insurance Company					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**

Carrier	Total Cases	Upheld		Overturned/Modified	
National Association of Letter Carriers Health Benefit Plan					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Navitus Health Solutions					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Optum					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Physicians Mutual Insurance Company					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
PlanSource					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Principal Life Insurance Company					
State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
SAG-AFTRA Health Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
SilverScript					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Sun Life and Health Insurance Company					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Teamsters Local 639 Health and Welfare Fund					
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	3	3	100%	0	0%
Total Complaints	**3**	**3**	**100%**	**0**	**0%**
United Behavioral Health					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
United Concordia Insurance Company					
Not State Regulated	14	9	64%	5	36%
Total Complaints	**14**	**9**	**64%**	**5**	**36%**
UnitedHealthcare					
State Regulated	37	14	38%	23	62%
Not State Regulated	51	24	47%	27	53%
Total Complaints	**88**	**38**	**43%**	**50**	**57%**
UPMC Health Plan					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
WellCare					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

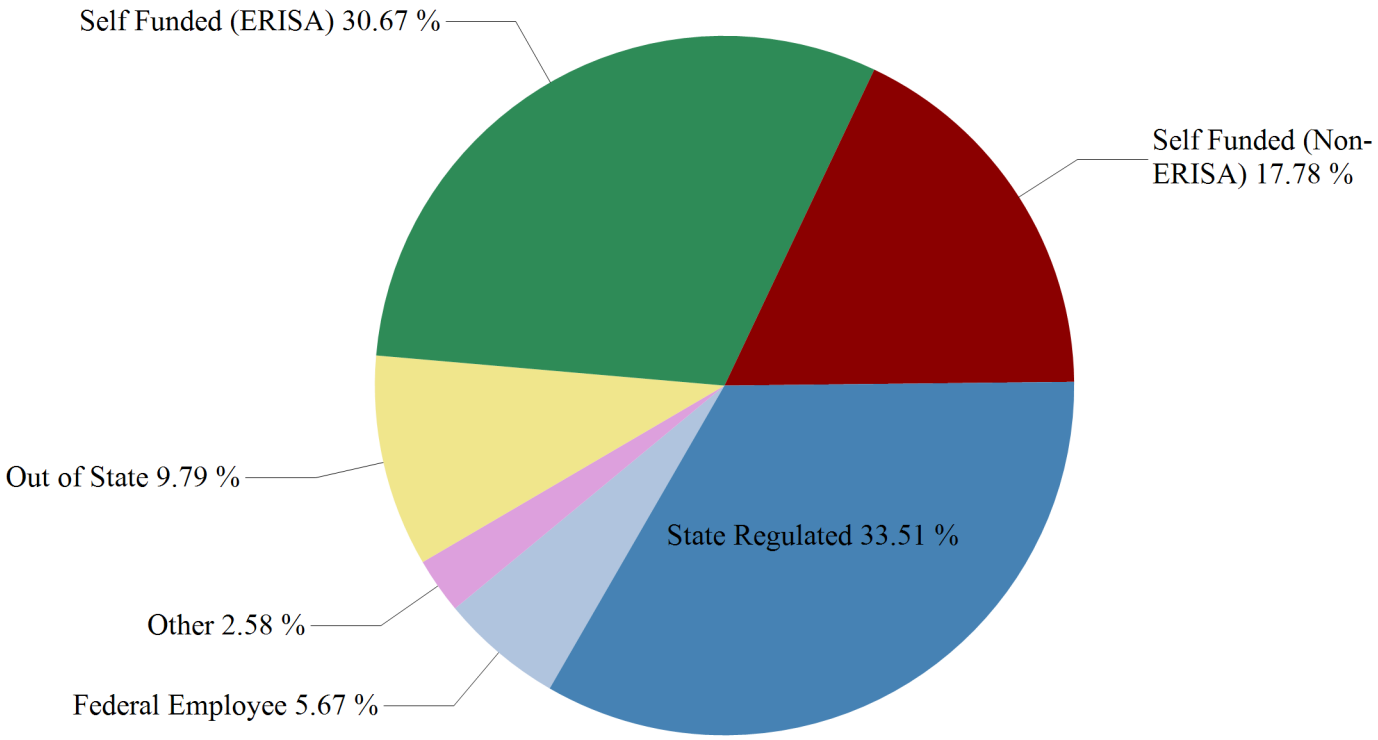
HEAU Mediated Appeals and Grievances Cases
Disposition

Carriers may uphold, overturn, or modify their decisions during the appeals and grievances process. The chart below identifies the outcomes of the Appeals and Grievances cases that the HEAU mediated and closed during FY 2021.



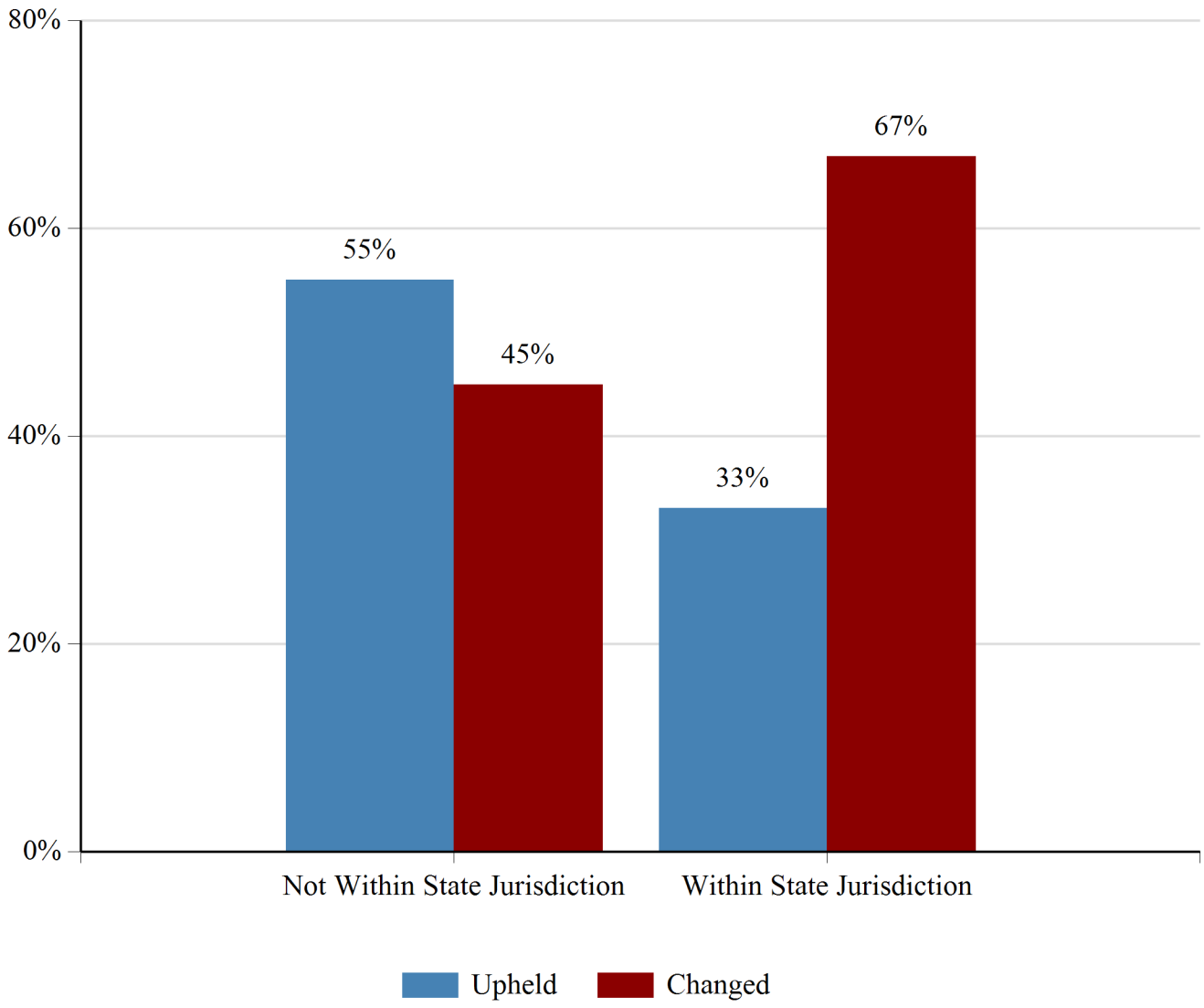
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the primary carrier types involved in the 388 Appeals and Grievances cases the HEAU mediated and closed during FY 2021.



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

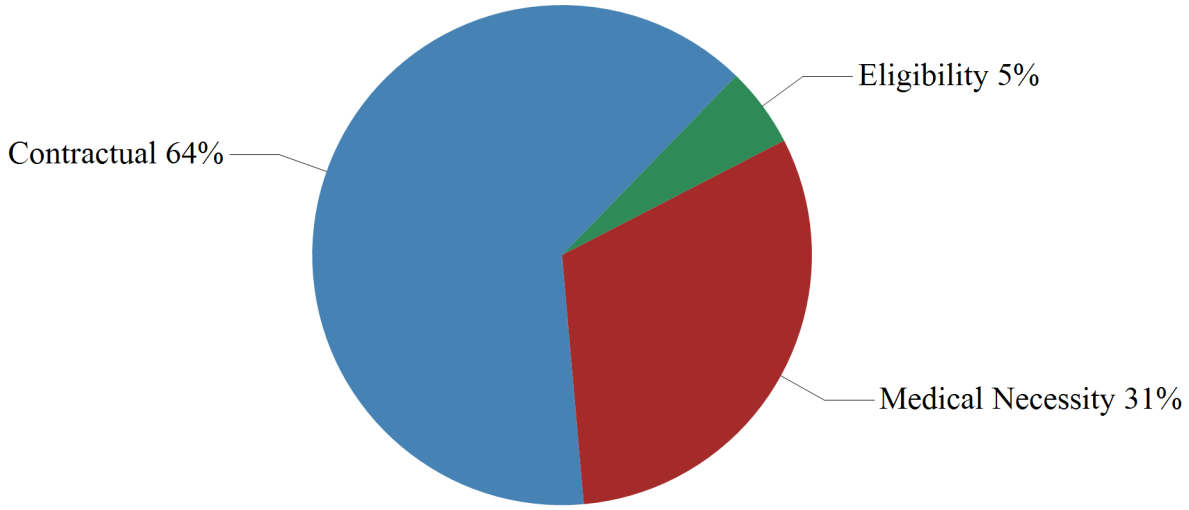
The chart below reflects the outcomes of the 388 Appeals and Grievances cases the HEAU mediated and closed during FY 2021 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

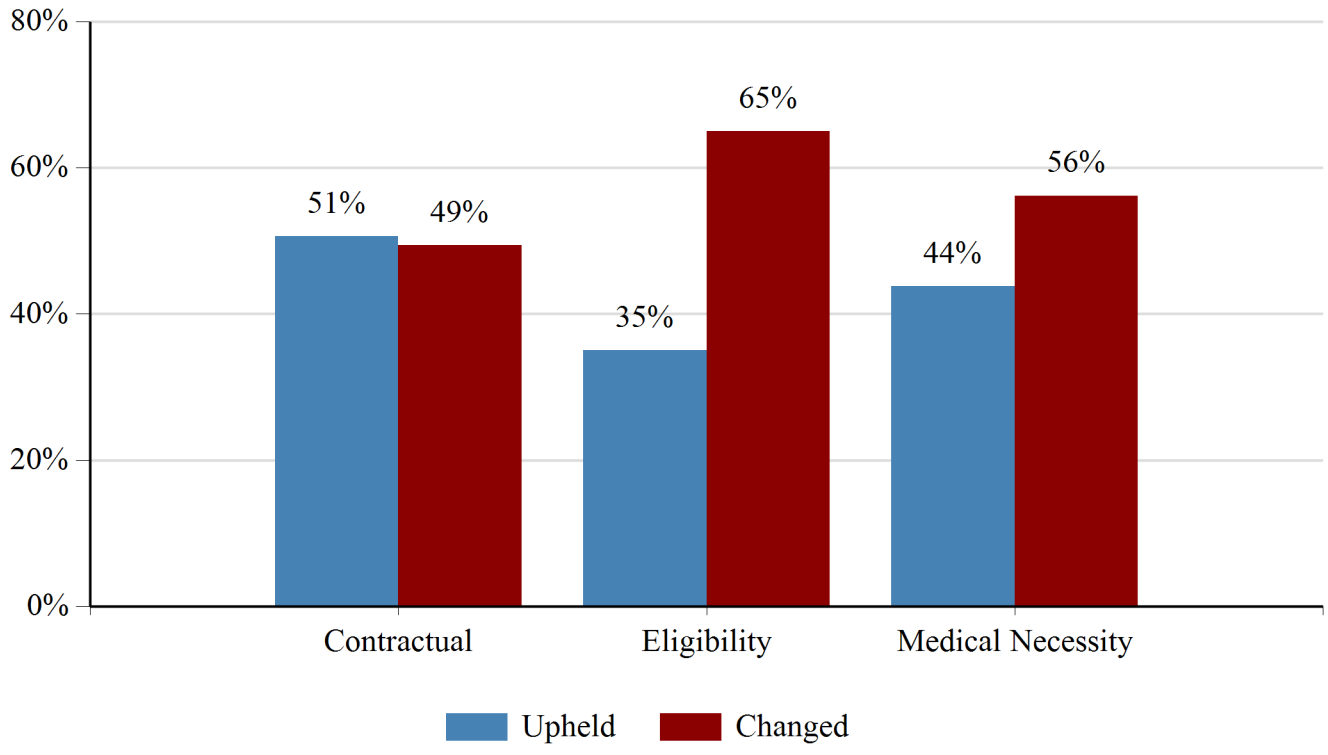
Types of Denials

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 2021.



Outcomes by Denial Type

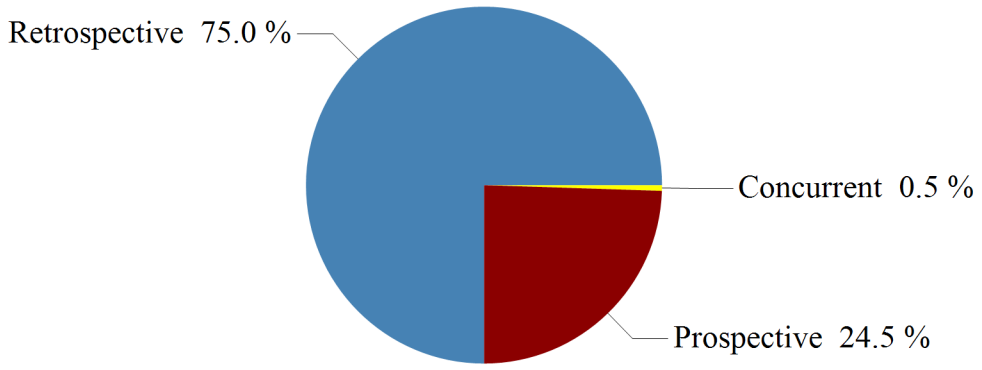
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2021.



HEAU Mediated Appeals and Grievances Cases

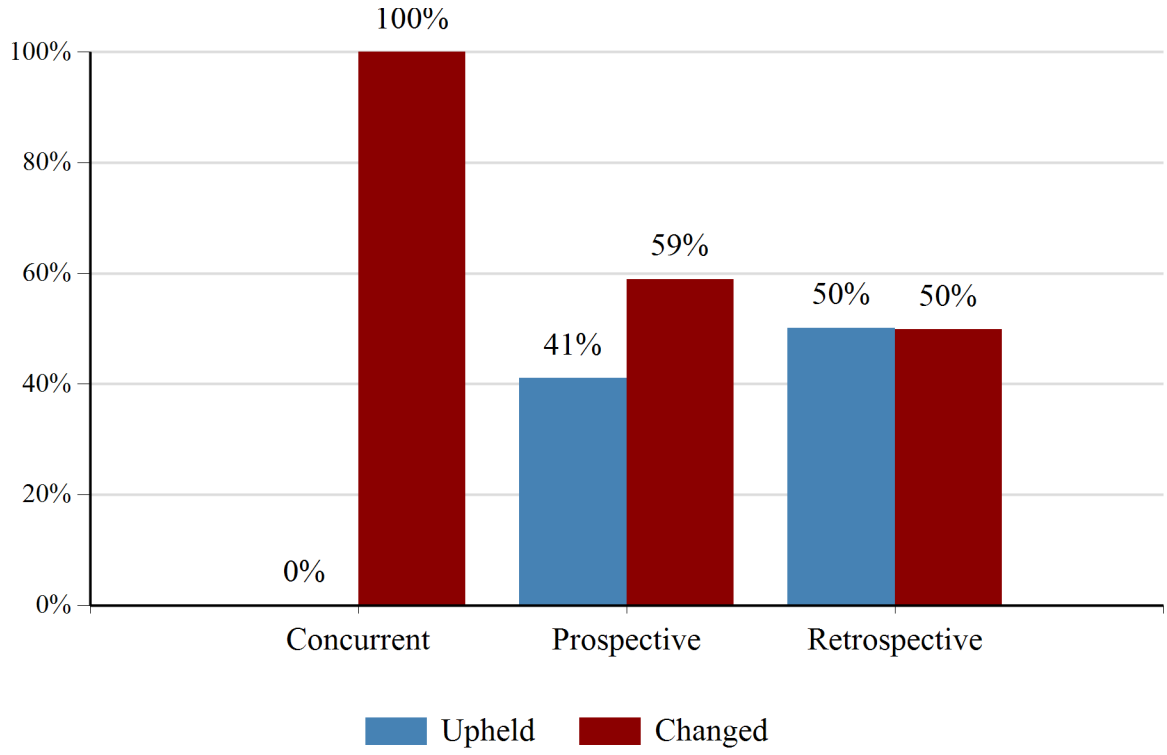
Timing of Denials

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 2021. Eligibility disputes are treated as prospective denials.



Outcomes by Timing of Denials

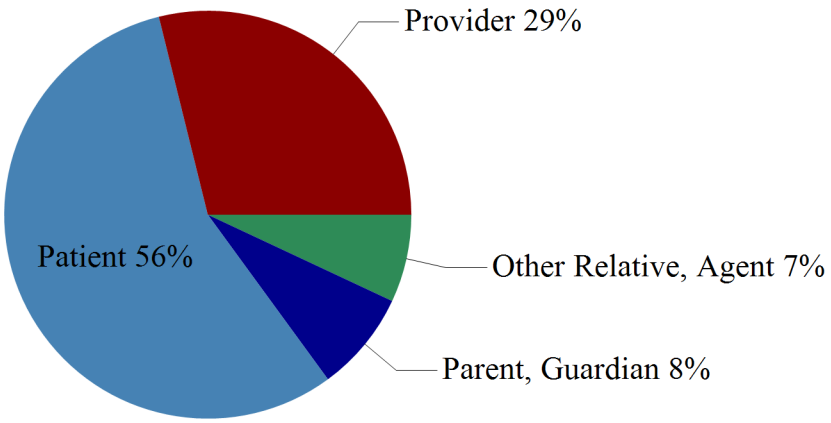
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2021 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

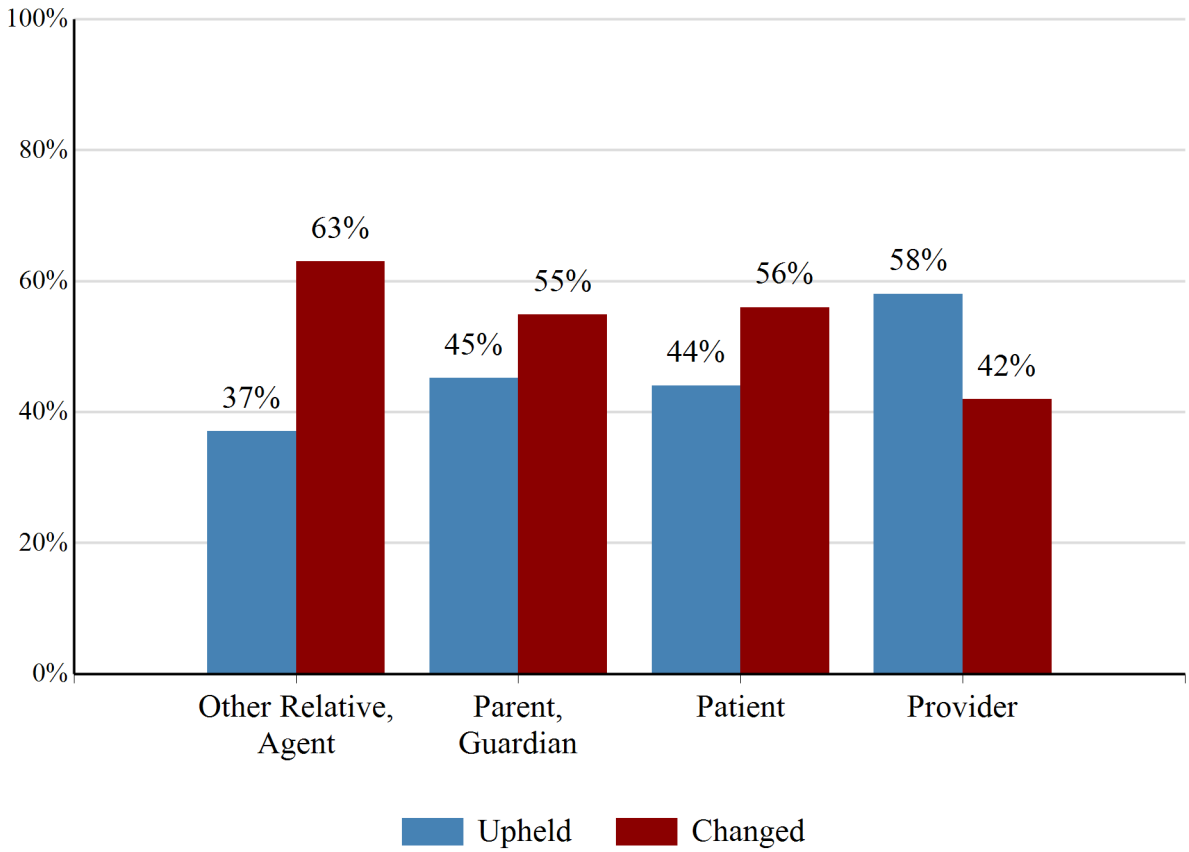
Who Filed the Case

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 2021.



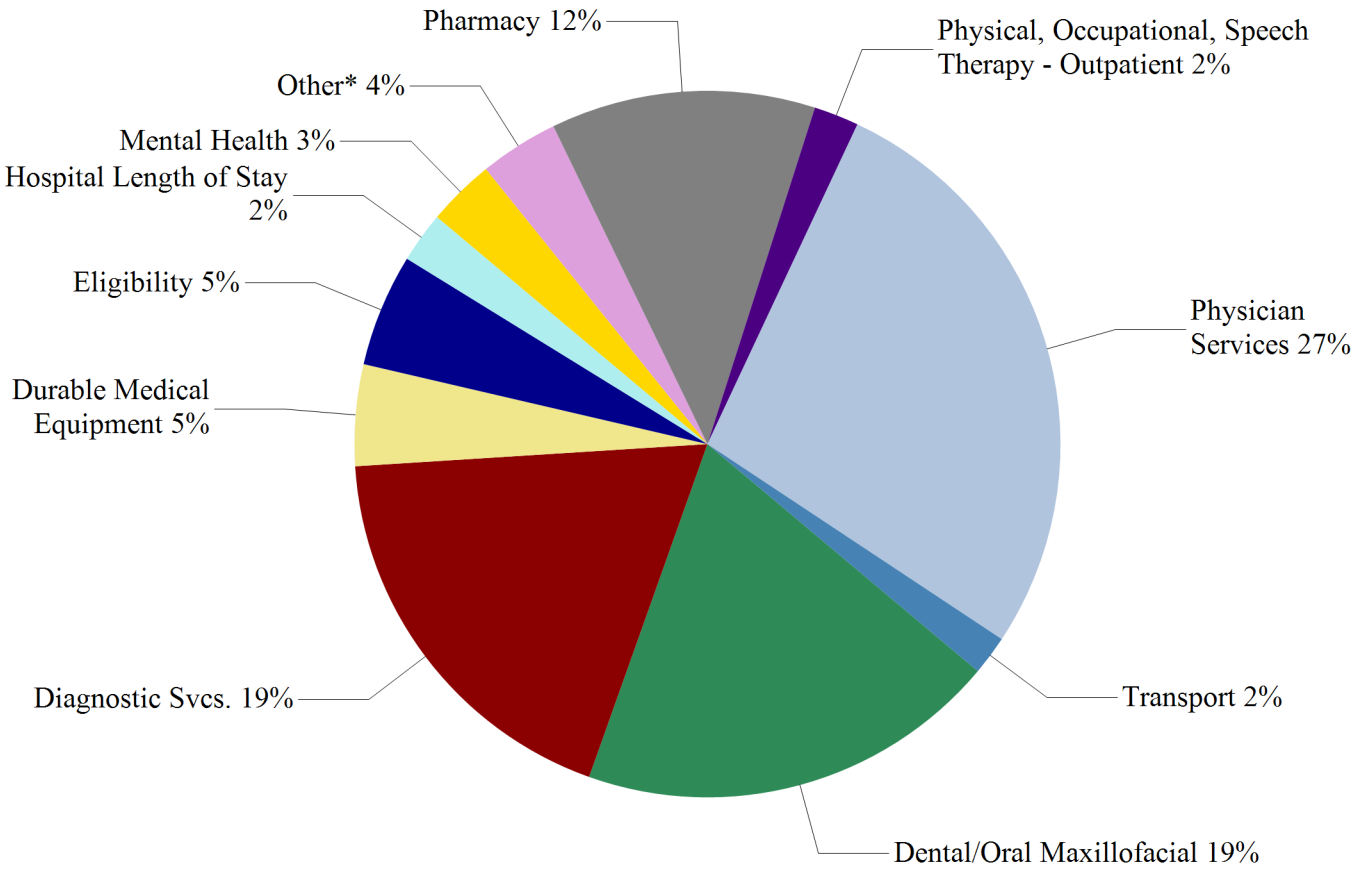
Outcomes by Who Filed the Case

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 2021.



HEAU Mediated Appeals and Grievances Cases
Types of Services Denied

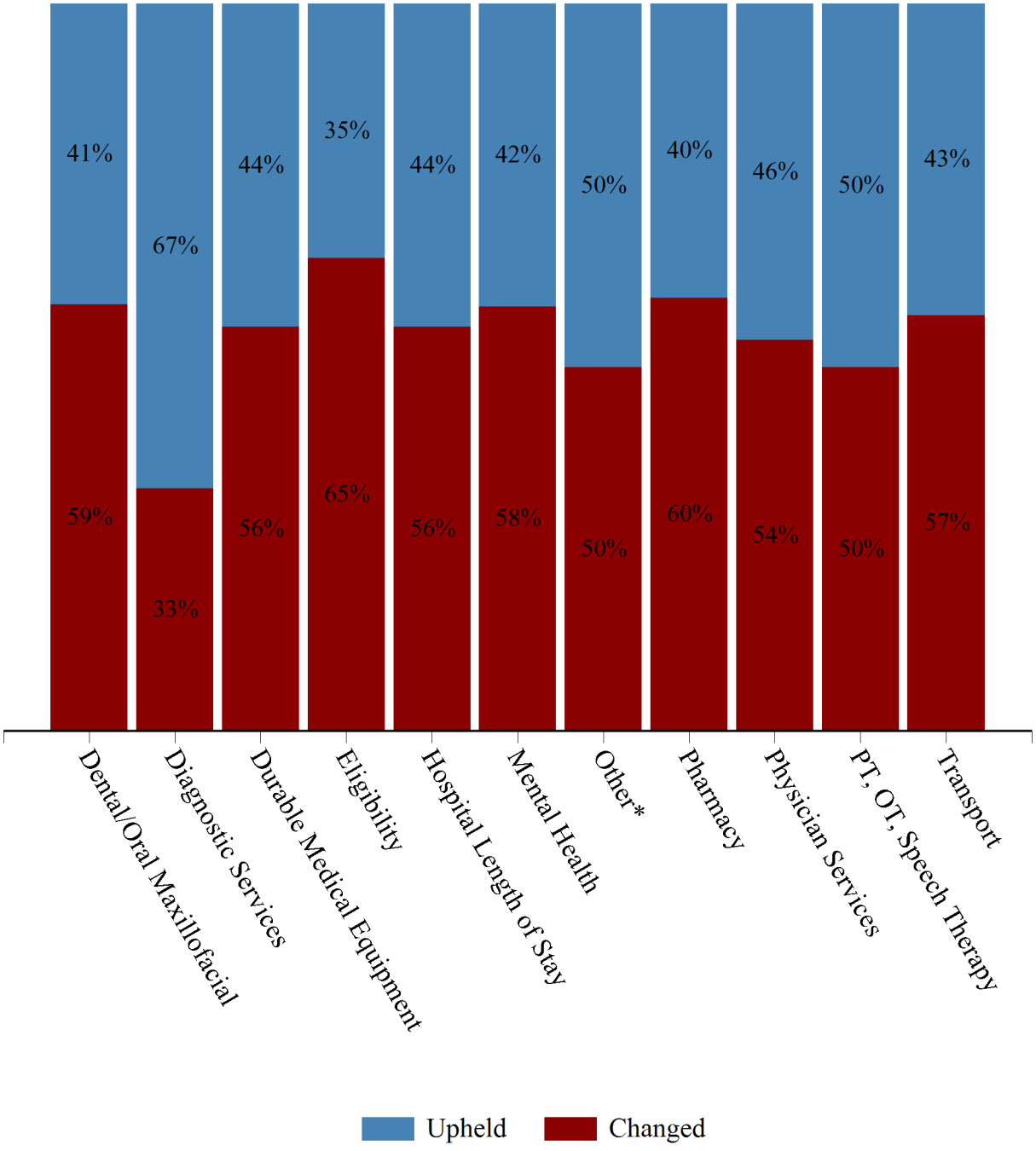
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2021.



* "Other" includes chiropractic, emergency room, home health, inpatient physical rehabilitation, optometry, products and supplements and skilled nursing facility.

HEAU Mediated Appeals and Grievances Cases
Outcomes by Service Type

The chart below compares the outcomes of the Appeals and Grievances cases the HEAU mediated and closed during FY 2021 based on the types of services denied.



* "Other" includes chiropractic, emergency room, home health, inpatient physical rehabilitation, optometry, products and supplements and skilled nursing facility.