State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

Prepared by:

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

Submitted to the Governor and General Assembly
MSAR # 1434 (#4)

Fiscal Year 2018

TABLE OF CONTENTS

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 2018, beginning July 1, 2017 and concluding June 30, 2018.

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 2018

In addition to the highlights below, charts providing statistical detail from the data submitted by the carriers appear on pages 18-26 of this report.

1. Carriers reported 76,115 adverse decisions in FY 2018, 9,015 more adverse decisions than reported in FY 2017. The number of adverse decisions issued by carriers has increased 76% over the last three fiscal years. In FY 2018, CareFirst BlueChoice, Inc. issued 40% more adverse decisions than in FY 2017; Dominion Dental Services, Inc. issued 45% more adverse decisions than in FY 2017; Kaiser Permanente Insurance Company issued 60% more adverse decisions than in FY 2017; Lincoln National Life Insurance Company issued 95% more adverse decisions than in FY 2017; MAMSI Life and Health Insurance Company issued 88% more adverse decisions than in FY 2017; United Concordia Insurance Company had more than a 100% increase in adverse decisions over FY 2017;[8] and UnitedHealthcare Insurance Company issued 52% more adverse decisions than in FY 2017. Other carriers had fewer adverse decisions issued in FY 2018 than in FY 2017.

2. The carriers administratively reversed only 248 of the reported adverse decisions, less than 1%.

3. In FY 2018, consumers filed 8,065 grievances, a 34% increase over the 6,012 grievances filed in FY 2017.

4. The largest percentage of grievances filed were in the dental (30%), pharmacy (37%), lab/radiology (16%) and physician (9%) service categories.

5. Overall, in FY 2018, during the internal grievance process, carriers altered 53% of their original adverse decisions, overturning 48% of their adverse decisions and modifying 5%.

6. Adverse decisions involving mental health/substance abuse services continue to be only rarely overturned or modified. In FY 2018, carriers reported an overturned or modified rate of only 25% for mental health and substance abuse services. This continues years of low reversal rates: 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.

[8] Conversely, United Concordia Life and Health Insurance Company issued 53% fewer adverse decisions than in FY 2017.

7. In FY 2018, dental decisions were overturned 64% 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: 60% in FY 2018, 65% in FY 2017, 71% in FY 2016, 62% in FY 2015, 79% in FY 2014, and 74% in FY 2013.

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.[9]

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

[9] 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 2018

MIA-provided data are reported on the charts and tables contained on pages 27-34 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 1,076 complaints in FY 2018. After reviewing these complaints, the MIA determined that 487 involved MIA-regulated adverse decisions.

2. The MIA referred 57 complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 430 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 276 cases (64%). The MIA upheld 154 (36%) of the carrier decisions.

4. Similar to FY 2017, the largest percentages of grievances filed were in the pharmacy (36%), dental care (17%), experimental (16%), 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 2018

The HEAU Appeals and Grievances data[10] are reported in the charts and tables contained on pages 35-53 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 2018.

The HEAU closed 2,290 cases in FY 2018.

1. 50% 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. 9% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection-related issues.

3. 1,000 of the complaints closed by the HEAU were appeals and grievances related cases. Not all of the 1,000 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 1,000 appeals and grievances cases the HEAU closed during FY 2018, 712 or 71% involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 712 cases involved more than one carrier.

4. Of the 712 appeals and grievances cases the HEAU mediated during FY 2018, 28.7% were adverse decision (*medical necessity*) cases, 62.6% were coverage decision (*contractual exclusion*) cases, and 8.7% were eligibility denials.

5. The HEAU mediation process resulted in 52% of the medical necessity cases, 48% 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 58% in cases involving at least one MIA-regulated plan. In cases involving non-regulated plans, the HEAU efforts resulted in a decision change 44% of the time.

7. In FY 2018, the HEAU assisted patients in recovering or saving over $2.8 million dollars, including nearly $2.4 million in appeals and grievances cases.

[10] 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 reflects, 49% 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.

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

1. A 47-year-old consumer diagnosed with high-risk prostate cancer was approved, pending coverage by his health insurance provider, to take part in an immunotherapy clinical trial, provided in six weekly doses beginning 50 days prior to his prostate removal surgery. According to his physician, the consumer's chance of survival with prostatectomy alone was 30% or less. The consumer's health insurance carrier refused coverage for the clinical trial contending the clinical trial was in the pilot stage and not in Phase I-IV, which would have been covered. The carrier's denial put the consumer at risk of exclusion from the clinical trial, which was limited to only 16 patients, and delayed the surgery to remove his prostate. The HEAU intervened, provided the necessary evidence to favorably resolve the clinical trial phase dispute, and coverage was approved the next day. The consumer recently reported that his cancer is now undetectable.

2. A 51-year-old woman went to the hospital because she was experiencing headache, confusion and pain. Upon arrival, hospital staff confirmed that their facility was in her HMO's network. Radiology and medical laboratory services were ordered as part of her workup, but her HMO denied payment for the services because the radiology and laboratory service providers were not part of her HMO's network. The HEAU helped the consumer successfully appeal the denied claims, resulting in savings of approximately $4,600.

3. A couple's daughter was born seven weeks premature at a Maryland hospital, requiring the newborn to stay for an extended time in the NICU. The consumers did not know that the neonatologists who treated their premature infant were out-of-network providers for their HMO. The neonatologists submitted claims to the HMO, which were denied. The HMO contended that the CPT codes were for services not consistent with care for a premature infant. The neonatologists' billing office maintained the CPT codes were correct; the HMO argued that they were not correct. The couple felt caught in the middle, and unable to break the impasse on their own, turned to the HEAU for assistance. After the HEAU's involvement, the CPT coding issues were resolved, saving the family approximately $4,300.

4. A single mother sought behavioral health treatment for her teenage daughter with issues of self-harm, involvement with sexual activities via the Internet, refusing to attend school, and outbursts requiring police intervention. Her daughter had multiple inpatient admissions for her safety and behavior. At discharge from the last admission, her daughter's psychiatrists felt she needed partial hospitalization. The family's HMO

offered one outpatient facility that would have been impossible for the mother to transport her daughter to and from in the morning and evening because it was too far from her employment location. The HMO was unable to provide partial hospitalization with a provider within a reasonable commute. The hospital and mother investigated appropriate referrals and found a residential program where her daughter was treated intensively for 3 months. The mother paid the $40,000 in charges with cash and credit cards. She requested payment/reimbursement from the HMO. The HMO refused to pay, based on lack of medical necessity, contending that the daughter could have been treated with twice weekly visits to HMO therapists or as an outpatient. The mother's attempted internal appeal failed and she sought the HEAU's assistance in obtaining reimbursement for the 3 months of intensive treatment. The HEAU appealed, contending that the daughter's records revealed escalating and treatment-resistant behavioral health issues that required intensive levels of treatment for stabilization. The HMO agreed to reimburse two months of charges, saving the mother $30,000. The appeal of the remaining month of treatment is pending at the MIA.

The HEAU addressed many marketplace concerns throughout the year, some new and some recurring. New concerns included the impact of federal risk adjustment rules and the State's new reinsurance program on health insurance rate review; State retirees' prescription drug coverage; potentially illegal health insurance advertising; quantity limits imposed on prescription drugs; commenting to the Maryland Department of Health regarding the State's Right to Try Act informed consent form; providing information to the prior authorization interim workgroup; providing air ambulance information to the U.S. Government Accountability Office; commenting to the Maryland Insurance Administration on its Mental Health Parity Market Conduct surveys; commenting to the Maryland Health Benefit Exchange on proposed regulations and plan certification standards; and commenting to the Maryland Medical Cannabis Commission on proposed medical cannabis advertising regulations, and presenting on the Consumer Protection Act to the Commission's Policy Committee.

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 Standardized Benefit Design Workgroup and the Maryland Health Care Commission's Health Information Exchange advisory work group.

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, joining amicus briefs opposing efforts to defund Planned Parenthood and roll back mandated coverage for contraception, the HEAU also worked with the Office and others to comment on federal regulations threatening to undermine protections for the health of the residents of the State and ensuring the availability of affordable health care.

Recurring concerns that the HEAU continued to address during FY 2018 included balance billing; mental health parity; network adequacy standards; consumers' rights to access medical records and obtain affordable copies under the HIPAA; medical privacy threats; consumer protections on the State's Health Information Exchange and State's Health Benefit Exchange; advanced medical directives; access to prescription drugs; and the opioid crisis.

The HEAU is focused on several other Areas of Concern:

A. Evergreen Health, Inc.

On July 31, 2017, the Circuit Court for Baltimore City appointed Risk & Regulatory Consulting, LLC as Receiver to rehabilitate or liquidate Evergreen Health, Inc. *Insurance Commissioner of Maryland v. Evergreen, Case No. 24-C-17-003939.* The Rehabilitation Order provided, in relevant part, that "all providers of health care services… which [have] provided or agreed to provide health care services to members or enrollees of Evergreen…are hereby permanently enjoined and restrained from…interrupting or discontinuing the delivery of health care services to such members or enrollees during the period for which they have paid (or because of a grace period have the right to pay) the required premium to Evergreen except as authorized by the Receiver…"

On September 1, 2017, the Circuit Court for Baltimore City ordered Evergreen to be liquidated. *Insurance Commissioner of Maryland v. Evergreen, Case No 24-C-17-003939.* The liquidation order also prohibited the interruption or discontinuation of care consistent with the Order of Rehabilitation.

In July 2017, the HEAU began receiving complaints from consumers, the MIA, the receiver and other third parties alleging that health care providers were refusing to treat Evergreen enrollees. For example, two consumers, scheduled to have cardiac defibrillators placed, were advised that their surgeries were cancelled because the hospital would not permit Evergreen enrollees to be on the surgical schedule unless they agreed to self-pay. The HEAU intervened, worked with the Office of Health Care Quality, the MIA, the receiver and the provider to ensure the patients obtained the surgical services to which they were entitled as Evergreen enrollees. Other hospital-affiliated community providers and independent providers refused to see or treat Evergreen enrollees during this time. The HEAU intervened to get the patients their care.

The Maryland Health Maintenance Organization Act, under Title 19 of the Maryland Health-General Article, affords Maryland HMO members legal protections, and prohibits health care providers from balance billing HMO members for covered services. *Maryland Code Ann., Health Gen. § 19-710 (p).* Health care providers may collect sums applied to member deductibles, coinsurance or copayments (collectively, "Member Cost Share"), but HMO members are not liable for amounts owed by the HMO to a contracted health care provider. *Maryland Code Ann., Health Gen. § 19-710 (p)(3).* Consistent with the Act, the Court's orders provided, in relevant part, that "all providers of health care services… which [have] provided or agreed to provide health care services to members or enrollees of Evergreen…are hereby permanently enjoined and restrained from: a. Seeking payment from any such member or enrollee for amount (sic) owed by Evergreen;..." The liquidation order prohibited any provider from seeking additional or unauthorized payment from Evergreen members or enrollees for health care services required to be provided under provider agreements.[11]

[11] On February 15, 2018, the Court issued an Order Establishing Bar Date and Approving Claims Procedures in the Evergreen matter that provided for the submission of claims by health care providers to the appointed receiver.

Unfortunately, the HEAU received many complaints from consumers, the MIA, the receiver and other third-parties alleging that health care providers, including hospital systems, laboratories, radiology practices, and independent providers, were billing consumers for amounts due by Evergreen, in apparent violation of Maryland law, the Court's orders and their provider agreements. The HEAU reached out to the providers, requesting that they cease and desist billing improperly and requesting full audits to identify any Evergreen members billed by the provider in amounts in excess of Member Cost Share amounts for covered services. The majority of the providers complied with HEAU's requests and refunded amounts improperly collected. The HEAU's review of the audit reports and improper billing practices is ongoing and could result in Consumer Protection Division enforcement.

B. Outpatient Facility Fees

As in FY 2016 and FY 2017, the HEAU continued to receive complaints about hospitals charging surprising and excessive fees in connection with physician office visits in outpatient facilities. Maryland's Health Services Cost Review Commission's ("HSCRC") current regulations do not require hospitals or providers to tell patients, when they make their appointments, that they will be billed by both the provider and the hospital for the visit. The HSCRC regulations also do not require that patients be informed about the amount of the hospital's fee, or that patients be provided a high-low estimate, at the time an appointment is made or when presenting at the registration desk for the appointment.[12] Patients consistently complain that they should have been given this information to make an informed decision about where to seek care. Some patients advise that would not have seen a doctor at the outpatient facility if the amount of the hospital's fee had been disclosed at the time of making an appointment. If told the fee amounts, they would have chosen to see the provider in a regular office, or if that is not an option, would have seen another provider in a setting where no facility fee is charged.

From a consumer viewpoint, current HSCRC regulations are inadequate because they merely require that a facility's location and signage alert "the public that a given building or service is either at the hospital or not at the hospital" and that "billing reflect clearly that the service is rate regulated or not rate regulated." Interestingly, the HSCRC has approved some floors of an outpatient facility as regulated space, and not others, making location and signage a nearly meaningless indicator for consumers. In addition, often the hospital outpatient facility is a physician's office that had been acquired by the hospital, but continues to appear to the public as a physician's office.

[12] Under Medicare regulations, in contrast, when an outpatient facility is not located on the main hospital's campus, and coinsurance will be charged by the physician and the hospital, the patient must be given written notice by the hospital before the delivery of services that states (1) the amount of the patient's potential financial liability or (2) if the amount is unknown, an explanation that the patient will incur coinsurance liability to the hospital which would not be incurred at a non-hospital facility, an estimate based on typical or average charges, and a statement that actual liability will depend on actual services furnished by the hospital. 42 CFR 413.65(g)(7)(i)(A)-(B).

Complaints reveal there is a big gap between what hospitals and regulators say consumers should understand about the fees based on signs and form language, and what consumers say they in fact understood - until they receive a surprise bill from the hospital.

As reported in FY 2017, the HEAU asked for documents and explanations from hospitals to establish when and how they provide patients notice of outpatient facility fees. The HEAU received responses from five Maryland hospital systems in connection with 15 complaints. The responses revealed that no hospital informs patients of the amount of the fee, or the high-low range of fees, at the time an appointment is made or at the time patients present to registration for their appointments.[13] The following is a summary of the hospitals' responsive information:

Hospital 1: No oral notice is given at time of making an appointment. "Our representatives do not verbally tell the patients when they schedule an appointment that there will be a facility fee charged." Pre-appointment documents are mailed to patients, including a billing notice that states "you will receive a physician services bill from the doctor and an outpatient clinic bill from [hospital name]. Together, the two bills will represent charges incurred during your visit to the center." The same notice is given to the patient for signature at the time of service. No information is given about the amount of the facility fee until the patient is billed. Six of the complaints about this hospital involve doctor/hospital fees of $454/$1,729, $425/$1,141, $475/$627, $297/$577, $345/$553 and $425/$296. The patients contend they did not understand they would be charged facility fees, or that they would be so high.

Hospital 2: One hospital outpatient campus never responded to the HEAU's requests. Another campus stated that the patient would not have been advised of the regulated facility fee during the appointment scheduling phone call. According to the hospital, an electronic "My Chart" appointment reminder is sent, including appointment instructions that state, in part: "1. Please arrive 20 minutes early to allow time for registration. 2. Please note this is a Hospital based clinic. You may have two co-pays or co-insurance amounts as well as receive a bill for both a professional fee and a facility fee." Two of the complaints about this hospital involve doctor/hospital fees of $91/$260 and $355/$143.

Hospital 3: According to the hospital, patients are notified by the name of the hospital on signs. The hospital asserted that it provides oral notice that facility fees may be charged at the time an appointment is made, contending that there is a script for schedulers to inform patients they are coming to a hospital-based center, and to advise patients to check with their insurers about what the patient will pay out of pocket. When time allows, pre-appointment papers are mailed along with a three-page document entitled "Understanding Your Medical Bill." The same document is given to patients in paperwork to be signed at the time of service. On page one, the document states: "Patients treated in an outpatient setting (for example, a clinic, emergency room, or surgery) or admitted to the hospital may receive multiple bills. You may have to pay a co-pay, deductible and/or co-insurance for the physician and hospital services. … The hospital outpatient bill includes charges for the

[13] It appears this fee information is available because the HEAU has received complaints that some hospitals, labs, radiology practices and other providers are requiring pre-payment of patient co-insurance and outstanding deductible amounts for professional services and hospital services, and that overpayments are not always reimbursed.

use of the hospital facility and any tests or procedures you undergo." Similar information is included on page three. Five of the complaints about this hospital involve doctor/hospital fees of $205/$1684, $119/$1,489, unknown/$1,342, $50/$327 and 3 charges for one patient ($225/$1,342, $155/$170 and $340/$138). The patients contend they did not understand they would be charged facility fees, or that they would be so high.

Hospital 4: No oral notice or specific written notice is provided about outpatient facility fees. Patients are advised in writing to check with their carrier about co-pays and deductibles. One of the complaints involved a $1,777 hospital fee. The patient said he did not know he would be charged a facility fee.

Hospital 5: The hospital reports its outpatient facility locations and signage make patients aware they will be billed a facility fee. The hospital says its regular practice is to orally notify patients at the time they register that "they will receive facility and physician fees for their treatment." This information "is contained in the Consent for Medical Treatment that is typically signed by patients at their first visit." One of the complaints involved doctor/hospital fees of $165/$165. The patient said he asked about costs when making the appointment and was advised only about a $50 co-pay.

The HEAU has concluded that patients need explicit cost information when making their appointments to avoid surprise bills for outpatient facility fees. The signage and vague language used by hospitals is ineffective; consumers continually fail to appreciate their financial risk because they are not told the exact fee or even a high-low range of fees at a time when they could choose another provider or treatment location. 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."

The HEAU believes that hospitals and providers are failing to provide consumers with material information and that this failure could violate the Maryland Consumer Protection Act. The HEAU's review is ongoing and could result in Consumer Protection Division enforcement. However, this problem may also warrant a regulatory or legislative response.

C. Prescription Drug Pricing

Numerous complaints were made in FY 2018 to the HEAU and the MIA 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, 10% were pharmacy-related. In addition, 36% of the grievances filed with the MIA were pharmacy-related. These numbers underscore the importance of the Essential Off-Patent or Generic Drug Price Gouging legislation enacted in the 2017 legislative session to combat unjustified and extreme price increases for essential drugs that have long been on the market and whose research and development costs were recouped long ago. The Office has filed a petition with the U.S. Supreme Court asking it to uphold Maryland's law and its right to protect its citizens, following an adverse decision by the Fourth Circuit Court of Appeals. The HEAU is hopeful this important consumer protection statute will withstand industry's attacks and contribute to improved drug affordability. The HEAU will continue to monitor pharmacy-related complaints for drug pricing and coverage issues that may merit future legislative action.

D. Genetic Privacy

The HEAU has been advocating for consumer protections increasing genetic privacy related to Direct to Consumer (DTC) genetic testing since the products started expanding five years ago. The HEAU has opposed legislative efforts to repeal Maryland's medical laboratory regulatory scheme that prohibits DTC genetic testing[14] and advertising,[15] thereby protecting tested consumers and their genetic relatives from genetic privacy risks arising out of the sale and disclosure of genetic information by testing companies. These laws enabled the Maryland Department of Health to deter an invasion of genetic privacy at a Ravens football game in 2017 where the tests were going to be given away to fans.

[14] COMAR 10.10.06.02 ("A laboratory may not perform a laboratory test, except under a health awareness permit or cholesterol permit, without obtaining written or electronic authorization from" a healthcare provider specified in the regulation.)

[15] Md. Code Ann., Health-General § 17-215 ("A person may not directly or indirectly advertise for or solicit business in this State for any medical laboratory, regardless of location, from anyone except a physician, hospital, medical laboratory, clinic, clinical installation, or other medical care facility.")

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.

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

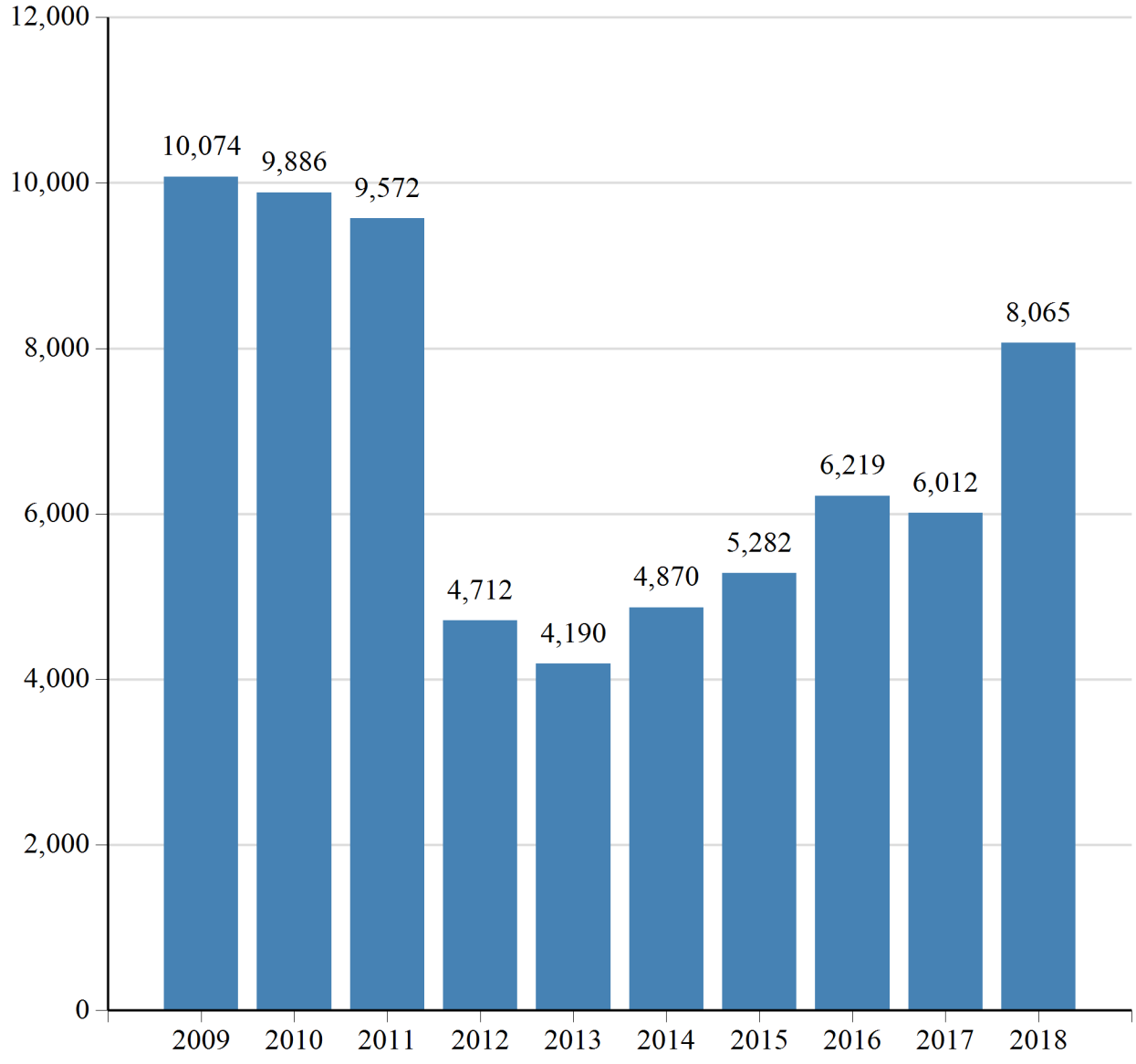
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
4 Ever Life Insurance Company	1	1	1	0%	100%
Aetna Dental Inc.	1,138	0	1	100%	0%
Aetna Health Inc. (a Pennsylvania corporation)	304	30	279	58%	42%
Aetna Life Insurance Company	278	36	166	58%	42%
Alpha Dental Programs, Inc.	4	0	0	0%	0%
Ameritas Life Insurance Corp.	115	0	43	63%	37%
BCS Insurance Company	0	0	1	100%	0%
CareFirst BlueChoice, Inc.	18,854	0	2,148	54%	46%
Carefirst of Maryland, Inc.	7,539	0	687	46%	54%
CIGNA Dental Health of Maryland, Inc.	69	0	1	100%	0%
CIGNA Health and Life Insurance Company	7,192	28	433	59%	41%
Connecticut General Life Insurance Company	4	0	30	63%	37%
Delta Dental Insurance Company	4	0	0	0%	0%
Delta Dental of Pennsylvania	15	0	0	0%	0%
Dental Benefit Providers of Illinois, Inc.	5,841	0	569	16%	84%
Dominion Dental Services, Inc.	627	0	99	33%	67%
Evergreen Health Cooperative Inc.	386	0	23	39%	61%
Evergreen Health, Inc.	11	0	4	75%	25%
Golden Rule Insurance Company	17	0	7	86%	14%
Group Dental Service of Maryland, Inc.	4,390	0	2	0%	100%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Group Hospitalization and Medical Services, Inc.	8,065	0	779	50%	50%
Guarantee Trust Life Insurance Company	0	0	2	100%	0%
Guardian Life Insurance Company of America	1,229	0	491	43%	57%
Johns Hopkins HealthCare LLC	18	0	34	47%	53%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	642	1	30	77%	23%
Kaiser Permanente Insurance Company	56	0	17	65%	35%
Lincoln Life & Annuity Company of New York	1	0	0	0%	0%
Lincoln National Life Insurance Company	234	103	0	0%	0%
MAMSI Life and Health Insurance Company	1,487	0	165	48%	52%
Metropolitan Life Insurance Company	295	48	27	70%	30%
National Health Insurance Company	7	0	1	0%	100%
Optimum Choice, Inc.	2,187	0	238	47%	53%
Principal Life Insurance Company	212	0	23	83%	17%
Reliance Standard Life Insurance Company	4	0	0	0%	0%
Standard Insurance Company	6	0	0	0%	0%
Sun Life Assurance Company of Canada	12	0	0	0%	0%
Unicare Life & Health Insurance Company	1	1	1	0%	100%
Union Security Insurance Company	724	0	48	35%	65%
United Concordia Dental Plans, Inc.	5	0	1	100%	0%
United Concordia Insurance Company	350	0	137	38%	62%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
United Concordia Life and Health Insurance Company	547	0	200	52%	48%
United States Life Insurance Company In the City of New York	1	0	1	0%	100%
UnitedHealthcare Insurance Company	12,451	0	1,320	41%	59%
UnitedHealthcare of the Mid-Atlantic, Inc.	792	0	56	55%	45%
Totals	**76,115**	**248**	**8,065**	**47%**	**53%**

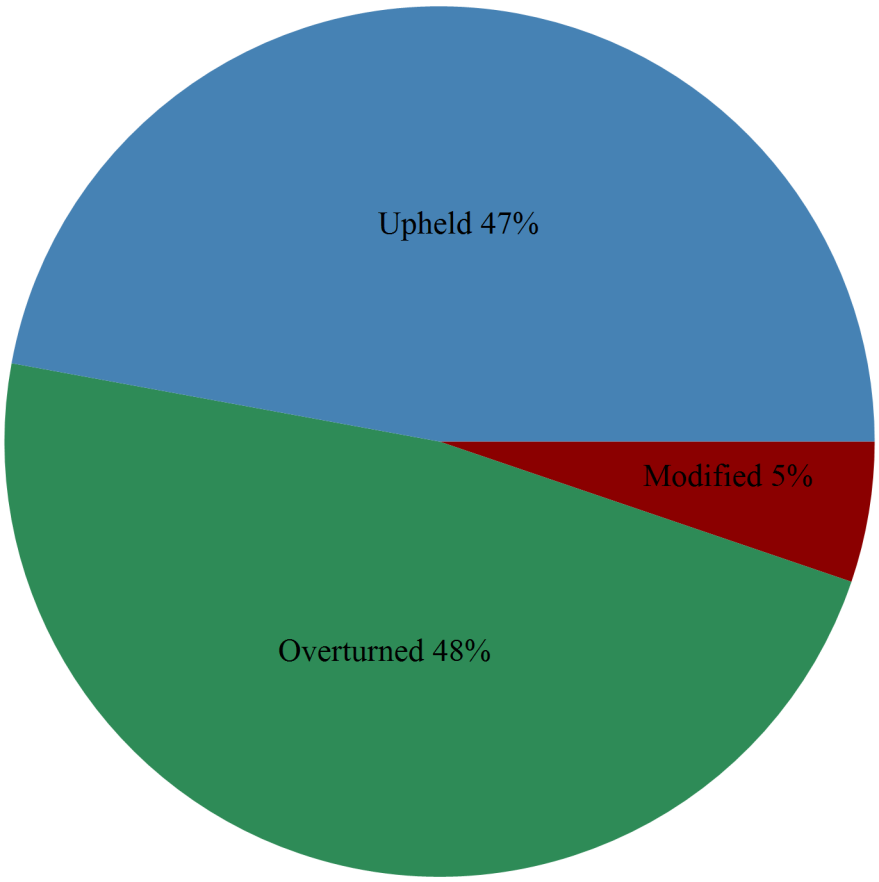
Carrier Grievances Cases
Number of Grievances Since Fiscal Year 2009

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.



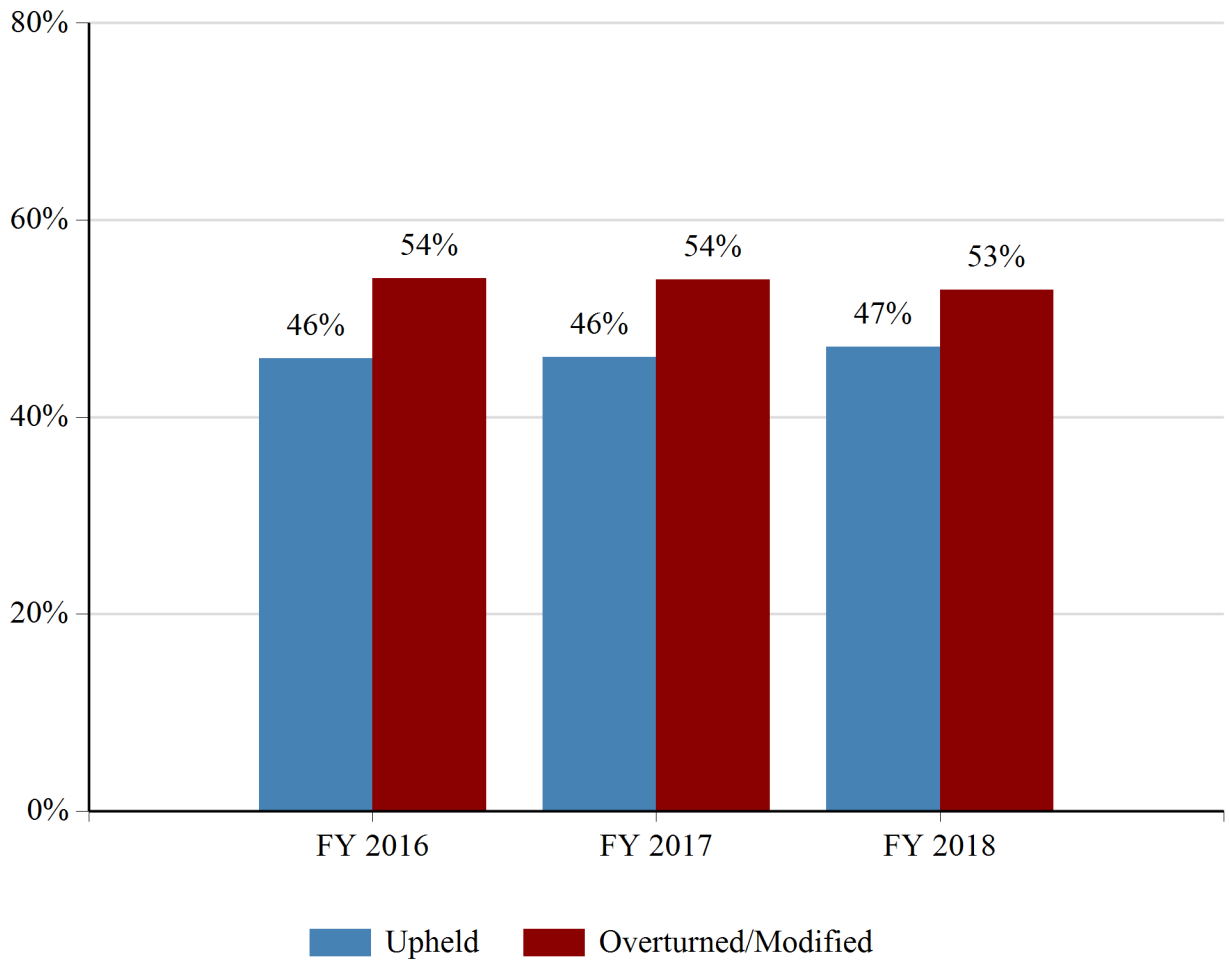
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 8,065 internal grievances filed with carriers in FY 2018, 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 2018, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	24,583	32.297%	2,454	30.428%
Durable Medical Equipment	1,161	1.525%	145	1.798%
Emergency Room	28	0.037%	4	0.050%
Home Health	224	0.294%	7	0.087%
Inpatient Hospital	1,294	1.700%	130	1.612%
Laboratory, Radiology	14,270	18.748%	1,304	16.169%
Mental Health / Substance Abuse	1,288	1.692%	108	1.339%
Other*	440	0.578%	170	2.108%
Pharmacy	24,939	32.765%	2,954	36.627%
Physician	6,589	8.657%	738	9.151%
PT, OT, ST, including inpatient rehabilitation	1,271	1.670%	38	0.471%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	28	0.037%	13	0.161%
Totals	**76,115**	**100%**	**8,065**	**100%**

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

Carrier Grievances Cases
Outcomes by Service Type

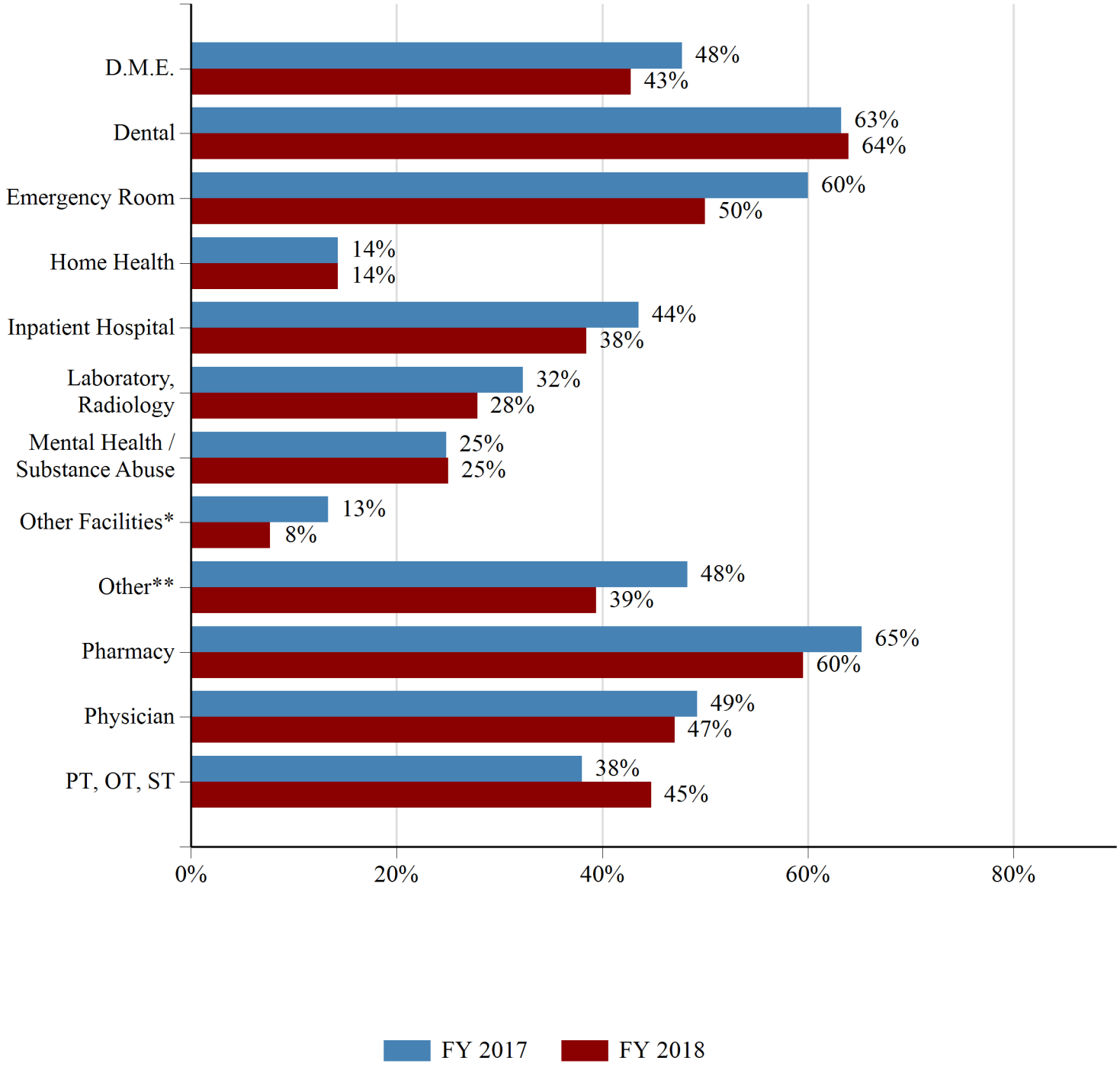
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Dental	2,454	36%	64%
Durable Medical Equipment	145	57%	43%
Emergency Room	4	50%	50%
Home Health	7	86%	14%
Inpatient Hospital	130	62%	38%
Laboratory, Radiology	1,304	72%	28%
Mental Health / Substance Abuse	108	75%	25%
Other*	170	61%	39%
Pharmacy	2,954	40%	60%
Physician	738	53%	47%
PT, OT, ST, including inpatient rehabilitation	38	55%	45%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	13	92%	8%
Totals	**8,065**	**47%**	**53%**

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

Carrier Grievances Cases
Two Year Comparison by Service Type

The chart below compares the percentages of grievances carriers overturned or modified by types of services, comparing FY 2017 and FY 2018.

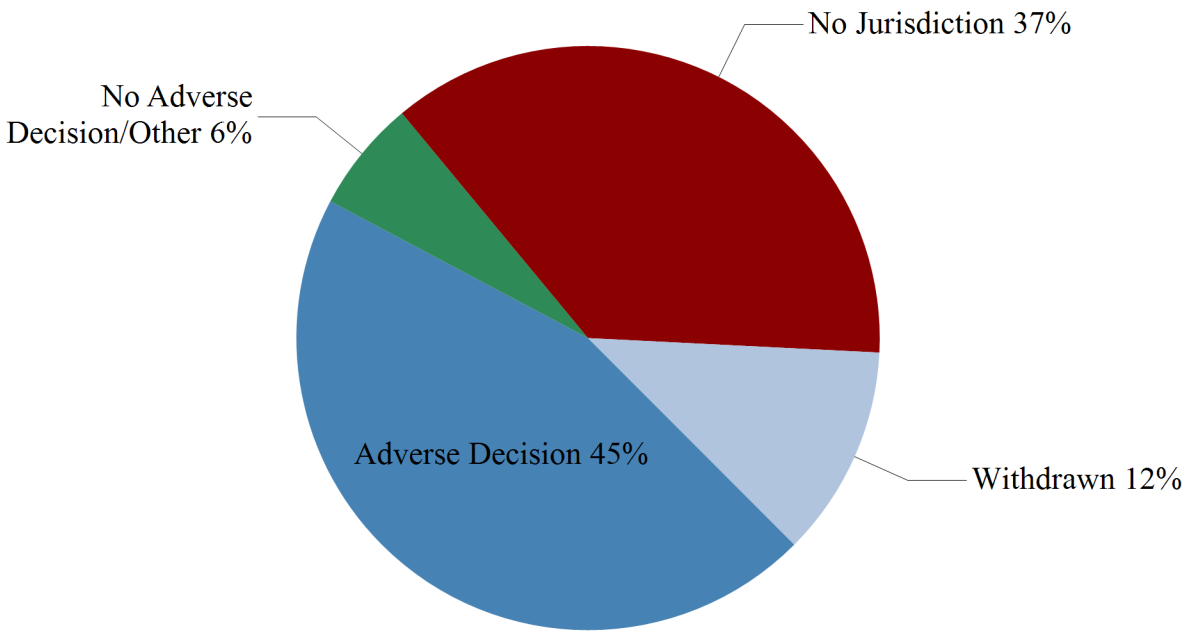


* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.
** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints
Initial Review of Cases

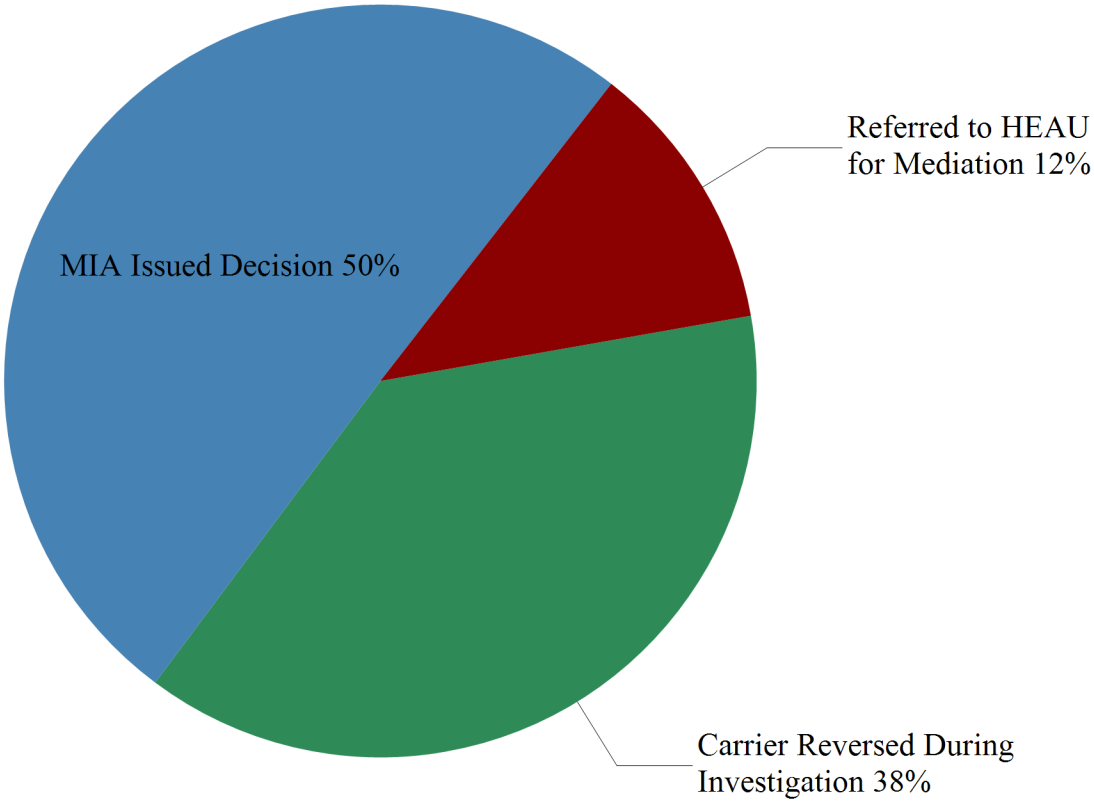
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some 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 1,076 cases filed with the MIA's Appeals and Grievances Unit during FY 2018.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2018, the MIA determined that 487 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 57 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 487 grievances the MIA reviewed during FY 2018.



MIA Appeals and Grievances Cases
Carriers and Disposition

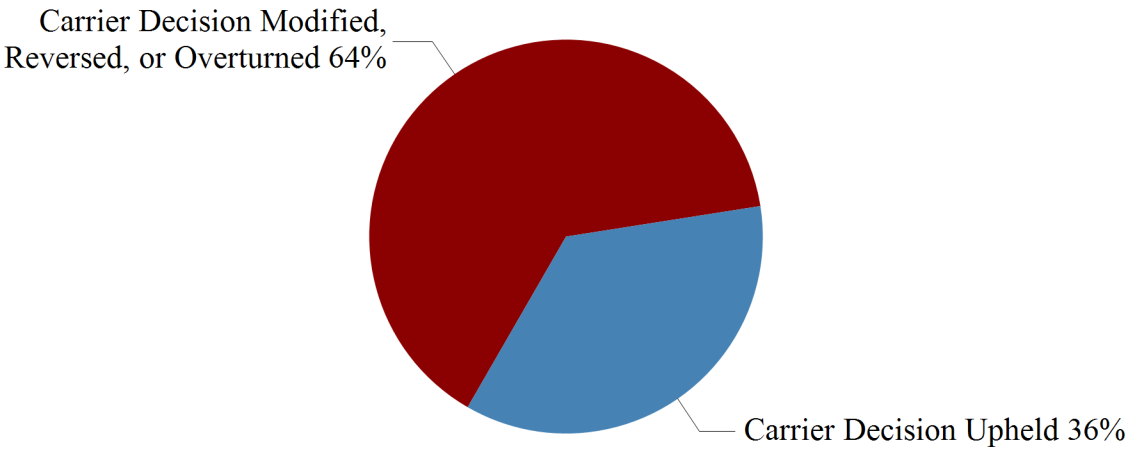
The table below details the outcomes of the 430 grievances complaints the MIA investigated during FY 2018. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	6	2	33.3%	2	33.3%	0	0.0%	2	33.3%
Aetna Life Insurance Company	7	2	28.6%	3	42.9%	0	0.0%	2	28.6%
Ameritas Life Insurance Corp.	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
CareFirst BlueChoice, Inc.	121	53	43.8%	24	19.8%	2	1.7%	42	34.7%
Carefirst of Maryland, Inc.	86	36	41.9%	14	16.3%	5	5.8%	31	36.0%
CaremarkPCS Health L.L.C.	6	0	0.0%	0	0.0%	0	0.0%	6	100.0%
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	16	7	43.8%	2	12.5%	0	0.0%	7	43.8%
CVS Caremark	4	0	0.0%	0	0.0%	0	0.0%	4	100.0%
Dominion Dental Services, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Evergreen Health, Inc.	3	1	33.3%	0	0.0%	0	0.0%	2	66.7%
Express Scripts, Inc.	4	0	0.0%	2	50.0%	0	0.0%	2	50.0%
Group Hospitalization and Medical Services, Inc.	26	13	50.0%	0	0.0%	1	3.8%	12	46.2%
Guardian Life Insurance Company of America	8	2	25.0%	2	25.0%	0	0.0%	4	50.0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	16	8	50.0%	2	12.5%	0	0.0%	6	37.5%
MAMSI Life and Health Insurance Company	6	1	16.7%	1	16.7%	1	16.7%	3	50.0%

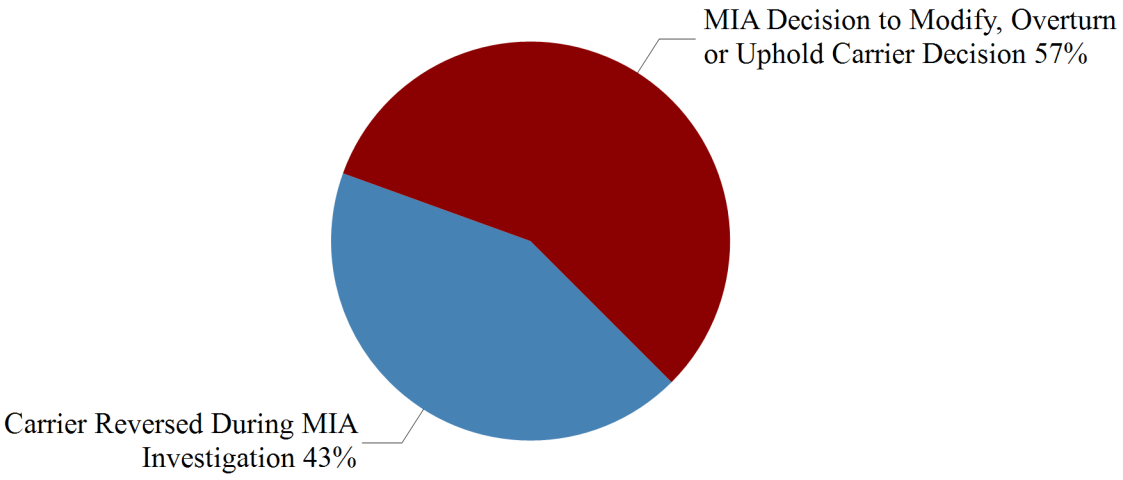
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Metropolitan Life Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Optimum Choice, Inc.	12	2	16.7%	2	16.7%	1	8.3%	7	58.3%
Principal Life Insurance Company	1	0	0.0%	1	100.0%	0	0.0%	0	0.0%
United Concordia Insurance Company	2	0	0.0%	1	50.0%	1	50.0%	0	0.0%
United Concordia Life and Health Insurance Company	13	3	23.1%	3	23.1%	2	15.4%	5	38.5%
UnitedHealthcare Insurance Company	75	20	26.7%	13	17.3%	2	2.7%	40	53.3%
UnitedHealthcare of the Mid-Atlantic, Inc.	8	2	25.0%	2	25.0%	0	0.0%	4	50.0%
UnitedHealthcare Services, Inc.	5	2	40.0%	2	40.0%	0	0.0%	1	20.0%
Totals	**430**	**154**	**36%**	**76**	**18%**	**15**	**3%**	**185**	**43%**

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 430 grievances the MIA investigated during FY 2018.

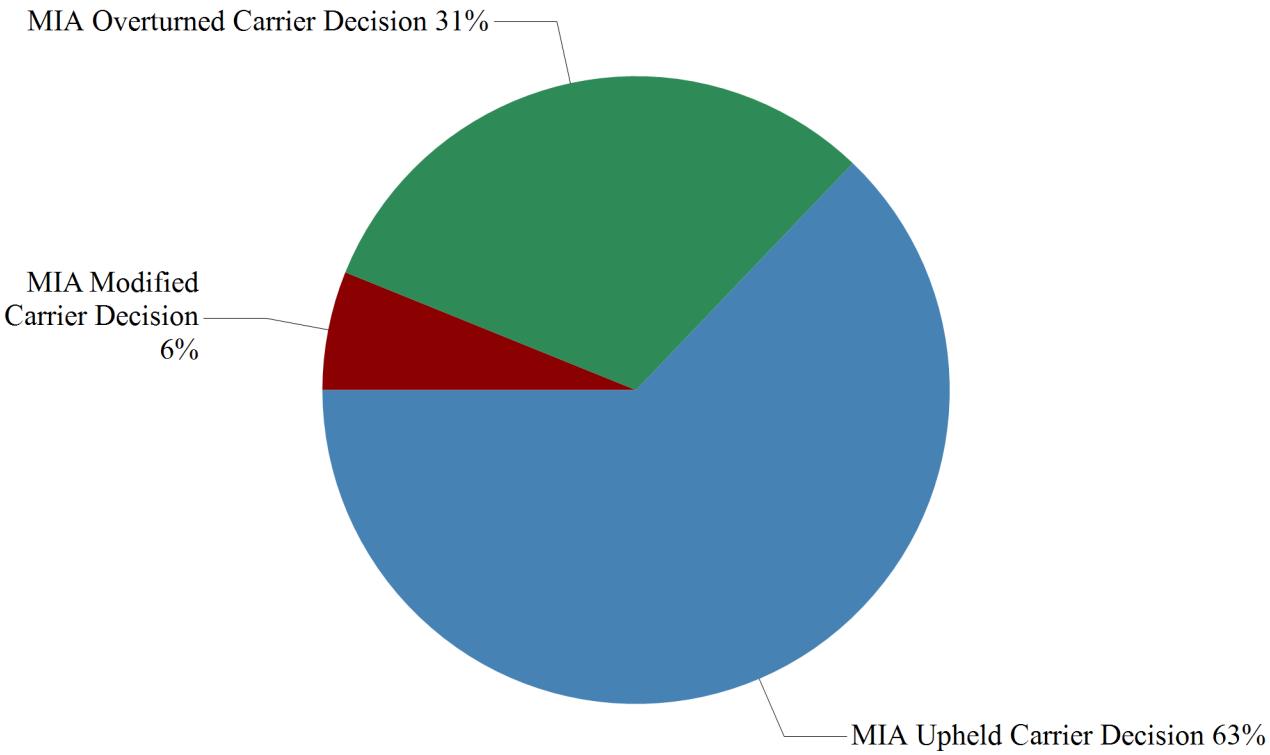


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 245 cases the MIA forwarded to an IRO for review in FY 2018.



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 2018. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

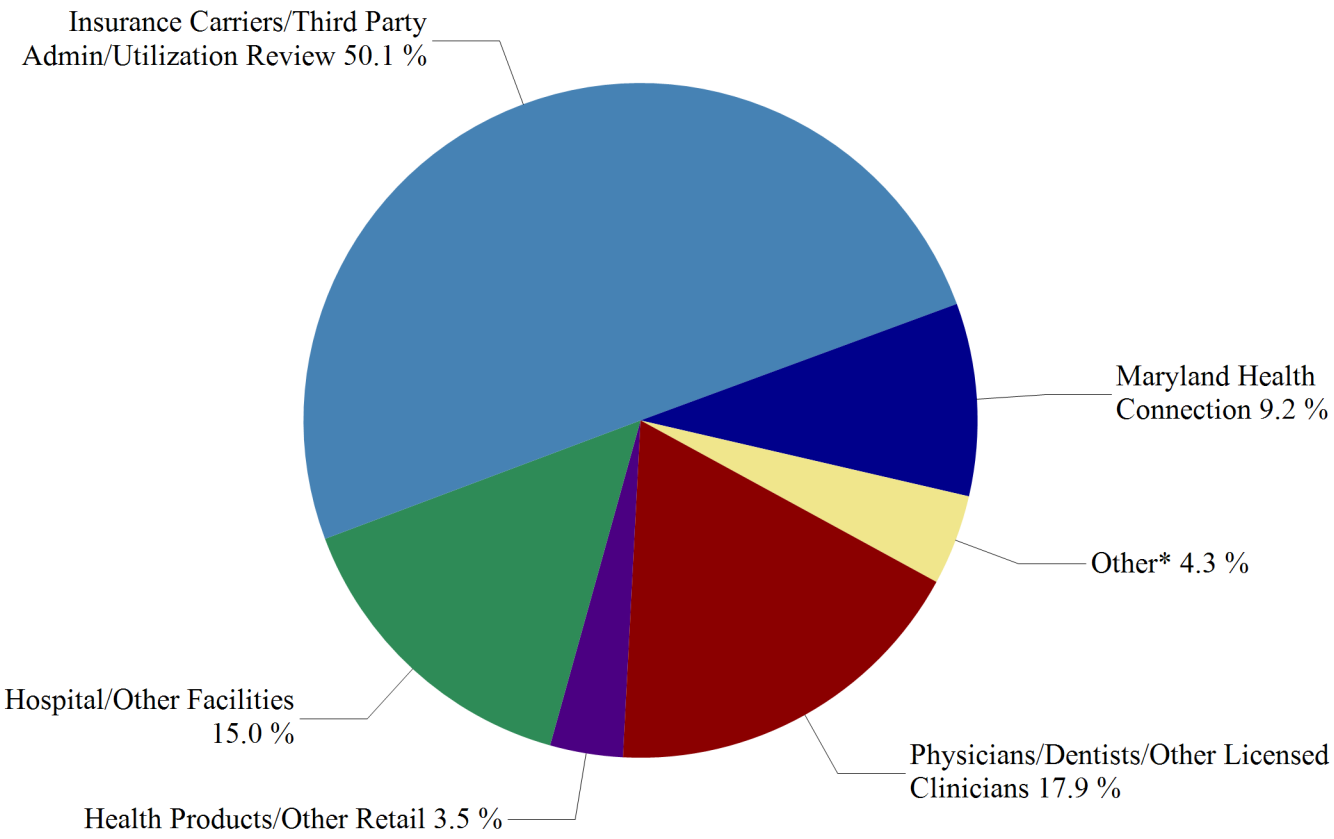
Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Acupuncture	1	0%	0	0%	0	0%	0	0%	1	100%
Air Ambulance	3	1%	3	100%	0	0%	0	0%	0	0%
Chiropractic Care Services	2	0%	0	0%	0	0%	0	0%	2	100%
Cosmetic	1	0%	1	100%	0	0%	0	0%	0	0%
Denial of Hospital Days	11	3%	3	27%	4	36%	1	9%	3	27%
Dental Care Services	72	17%	25	35%	14	19%	6	8%	27	38%
Durable Medical Equipment	14	3%	6	43%	1	7%	1	7%	6	43%
Emergency Room Denial	1	0%	0	0%	0	0%	0	0%	1	100%
Experimental	67	16%	45	67%	17	25%	3	4%	2	3%
Eye Care Services	2	0%	0	0%	1	50%	0	0%	1	50%
Home Care Services	1	0%	0	0%	0	0%	0	0%	1	100%
In-Patient Rehabilitation Services	1	0%	0	0%	0	0%	0	0%	1	100%
Lab, Imaging, Test Services	26	6%	10	38%	4	15%	0	0%	12	46%
Lymphedema Treatment	1	0%	0	0%	1	100%	0	0%	0	0%
Medical Food	2	0%	0	0%	0	0%	0	0%	2	100%
Mental Health Partial Hospitalization	1	0%	0	0%	1	100%	0	0%	0	0%
Mental Health/Substance Abuse (Inpatient) Services	4	1%	3	75%	0	0%	0	0%	1	25%
Mental Health/Substance Abuse (Outpatient) Services	4	1%	1	25%	1	25%	0	0%	2	50%
Opioid Use Disorders	18	4%	4	22%	4	22%	0	0%	10	56%
PCP Referrals	2	0%	2	100%	0	0%	0	0%	0	0%

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Pharmacy Benefits	7	2%	1	14%	0	0%	0	0%	6	86%
Pharmacy Services/Formulary Issues	146	34%	32	22%	22	15%	2	1%	90	62%
Physician Services	38	9%	14	37%	6	16%	1	3%	17	45%
PT, OT, ST Services	4	1%	3	75%	0	0%	1	25%	0	0%
Transportation Services	1	0%	1	100%	0	0%	0	0%	0	0%
Totals	**430**	**100%**	**154**	**36%**	**76**	**18%**	**15**	**3%**	**185**	**43%**

Percentages may not equal 100% due to rounding.

HEAU Cases
Subject of Complaints

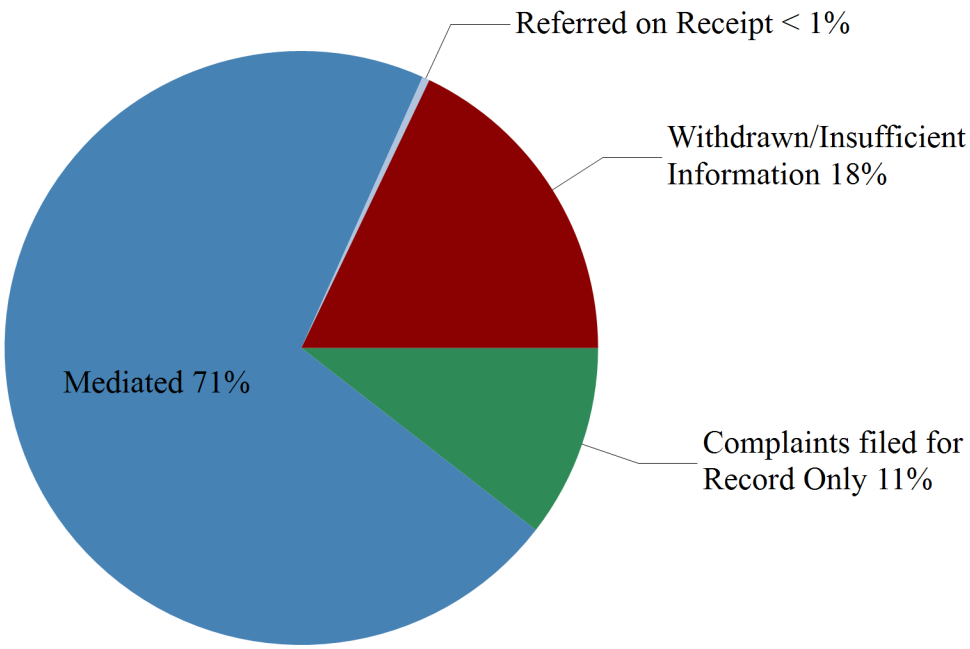
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, 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 2018. The HEAU closed 2,290 complaints. Some complaints were filed against more than one industry.



* "Other" includes Collection/Billing Entities (1.5%), Government Agency (1.1%), Ambulance (.5%), and other non-specific categories (e.g. Employer) (1.2%).

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 1,000 Appeals and Grievances cases closed by the HEAU during FY 2018.



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 2018. "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 712 cases in FY 2018. 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	2	33%	4	67%
Not State Regulated	36	17	47%	19	53%
Total Complaints	**42**	**19**	**45%**	**23**	**55%**
All Savers Insurance Co.					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Ameritas Life Insurance Corp.					
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 Ohio					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Anthem Grievances and Appeals					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Anthem UM Services, Inc.					
Not State Regulated	4	2	50%	2	50%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Beacon Health Options					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Blue Cross Blue Shield of Illinois					
Not State Regulated	8	8	100%	0	0%
Total Complaints	**8**	**8**	**100%**	**0**	**0%**
Blue Cross Blue Shield of Michigan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
BlueCross and BlueShield of Minnesota					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Carday Associates, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CareFirst					
State Regulated	95	46	48%	49	52%
Not State Regulated	79	39	49%	40	51%
Total Complaints	**174**	**85**	**49%**	**89**	**51%**
CareFirst Administrators					
Not State Regulated	7	4	57%	3	43%
Total Complaints	**7**	**4**	**57%**	**3**	**43%**
CareFirst the Dental Network					
State Regulated	20	5	25%	15	75%
Not State Regulated	5	2	40%	3	60%
Total Complaints	**25**	**7**	**28%**	**18**	**72%**
CIGNA					
State Regulated	11	6	54.5%	5	45.5%
Not State Regulated	82	58	71%	24	29%
Total Complaints	**93**	**64**	**69%**	**29**	**31%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Compass Rose Health Plan					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Conifer Health Solutions					
Not State Regulated	4	4	100%	0	0%
Total Complaints	**4**	**4**	**100%**	**0**	**0%**
Connecticare					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
CoreSource					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
CVS Caremark					
State Regulated	16	3	19%	13	81%
Not State Regulated	15	4	27%	11	73%
Total Complaints	**31**	**7**	**23%**	**24**	**77%**
Davis Vision					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Delta Dental					
State Regulated	4	2	50%	2	50%
Not State Regulated	3	2	67%	1	33%
Total Complaints	**7**	**4**	**57%**	**3**	**43%**
Delta Dental of Virginia					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Dominion National					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Ebix Health Administration Exchange Inc.					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Electrical Welfare Trust Fund					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Evergreen Health, Inc.					
State Regulated	28	6	21%	22	79%
Total Complaints	**28**	**6**	**21%**	**22**	**79%**
eviCore Healthcare					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Excellus Blue Cross Blue Shield					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Express Scripts					
Not State Regulated	4	2	50%	2	50%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**
FCE Benefits Administrators					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
FELRA & UFCW Health and Welfare Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Foreign Service Benefit Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
GEM Group					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Gerber Life Insurance Company					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Golden Rule Insurance					
State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Government Employees Health Association (GEHA)					
Not State Regulated	4	3	75%	1	25%
Total Complaints	**4**	**3**	**75%**	**1**	**25%**
Group Benefit Services, Inc.					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Group Dental Service of Maryland, Inc.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Guarantee Trust Life Insurance Company					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Guardian Life insurance Company of America					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Healthgram, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Highmark					
Not State Regulated	3	2	67%	1	33%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Humana Health Insurance					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Humana Insurance Company (Dental)					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
IHC Health Solutions					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Independence Blue Cross Blue Shield					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
IUOE Local 99 & 99-A Health and Welfare Fund					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Johns Hopkins Advantage MD					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Johns Hopkins Employer Health Programs					
Not State Regulated	4	1	25%	3	75%
Total Complaints	**4**	**1**	**25%**	**3**	**75%**
Johns Hopkins HealthCare LLC					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Johns Hopkins US Family Health Plan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	35	19	54%	16	46%
Not State Regulated	4	1	25%	3	75%
Total Complaints	**39**	**20**	**51%**	**19**	**49%**

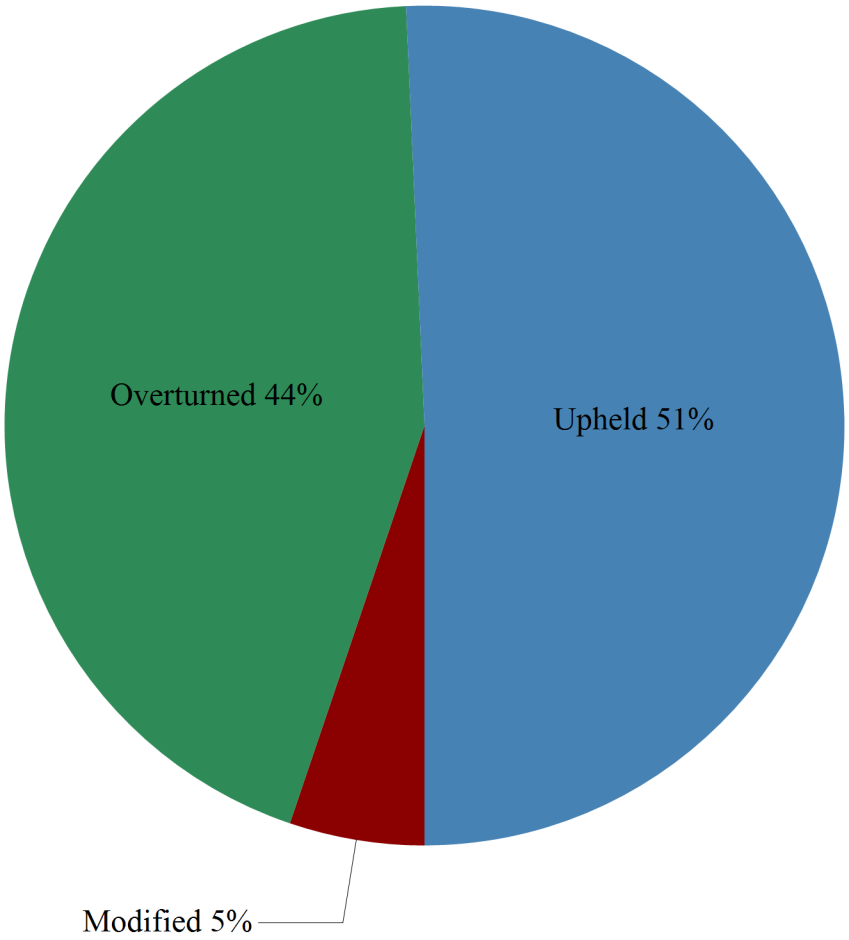
Carrier	Total Cases	Upheld		Overturned/Modified	
Maryland Health Connection					
State Regulated	14	4	29%	10	71%
Total Complaints	**14**	**4**	**29%**	**10**	**71%**
MDIPA | UnitedHealthcare					
Not State Regulated	6	0	0%	6	100%
Total Complaints	**6**	**0**	**0%**	**6**	**100%**
Medical Assistance					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
MedStar Select					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Meritain Health					
State Regulated	3	0	0%	3	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
Metropolitan Life Insurance Company					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
MidAtlantic Regional Council of Carpenter's Health Fund					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
NALC Benefit Plan					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
National Claims Administrative Services					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
National General Accident and Health					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
National Health Insurance Company					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Omaha Insurance Company					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Optimum Choice					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Premera Blue Cross of Washington State					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Quantum Health					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Silverscript					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Standard Security Life Insurance Company of New York					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Starmark					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
The Lincoln National Life Insurance Company					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
The Loomis Company					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Transamerica Life Insurance Company					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Tricare					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
UMR					
Not State Regulated	4	2	50%	2	50%
Total Complaints	**4**	**2**	**50%**	**2**	**50%**
United Behavioral Health					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
United Concordia Insurance Company					
State Regulated	4	2	50%	2	50%
Not State Regulated	40	28	70%	12	30%
Total Complaints	**44**	**30**	**68%**	**14**	**32%**
UnitedHealthcare					
State Regulated	49	20	41%	29	59%
Not State Regulated	73	39	53%	34	47%
Total Complaints	**122**	**59**	**48%**	**63**	**52%**
Wellmark BlueCross BlueShield					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
WellNet					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Zenith American Solutions					
Not State Regulated	3	0	0%	3	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**

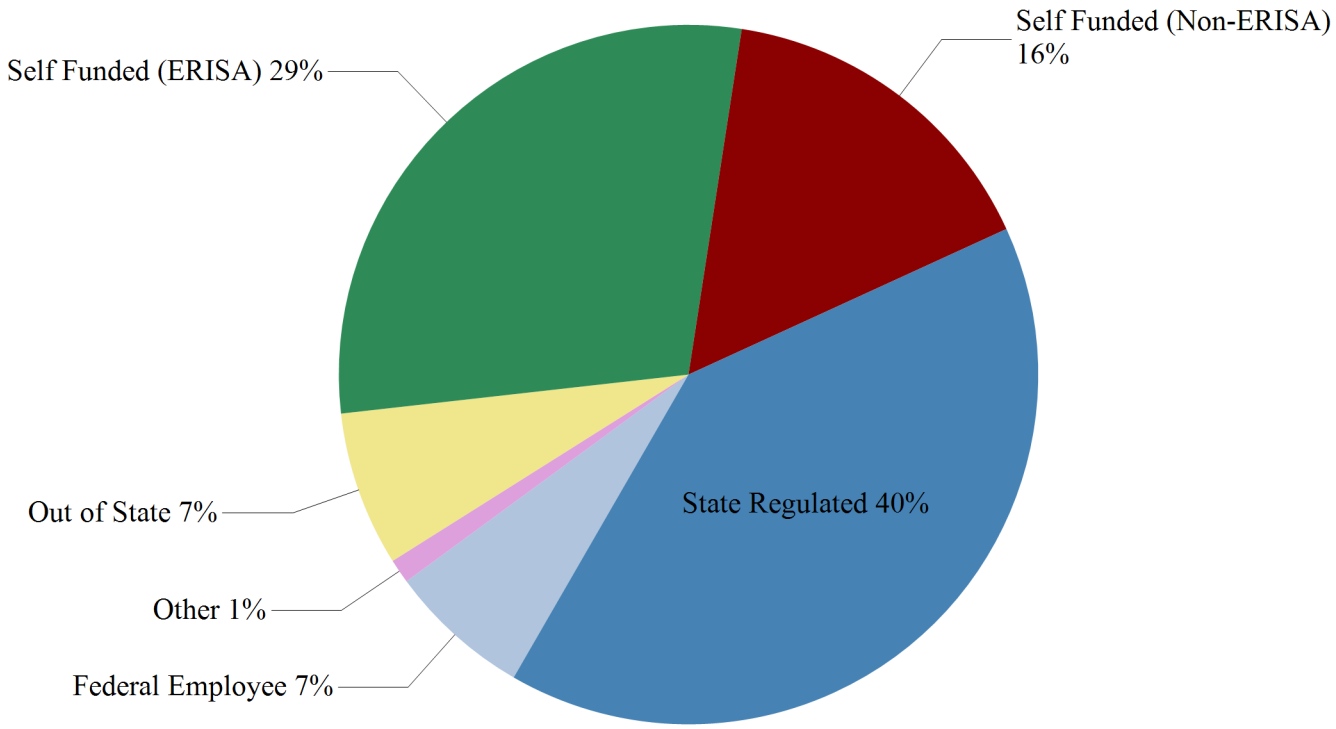
HEAU Mediated Appeals and Grievances Cases
Disposition

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 2018.



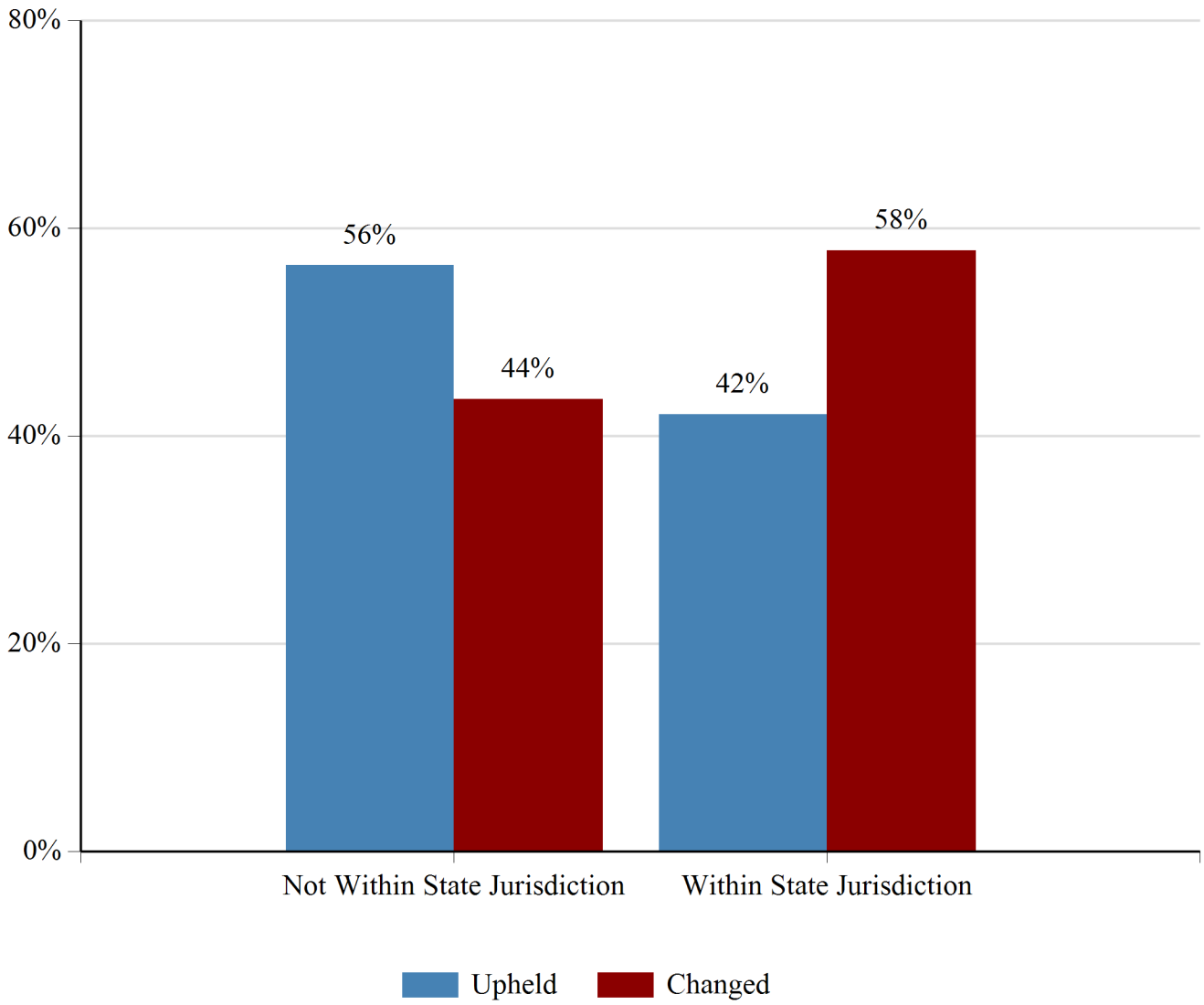
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the primary carrier types involved in the 712 Appeals and Grievances cases the HEAU mediated and closed during FY 2018.



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

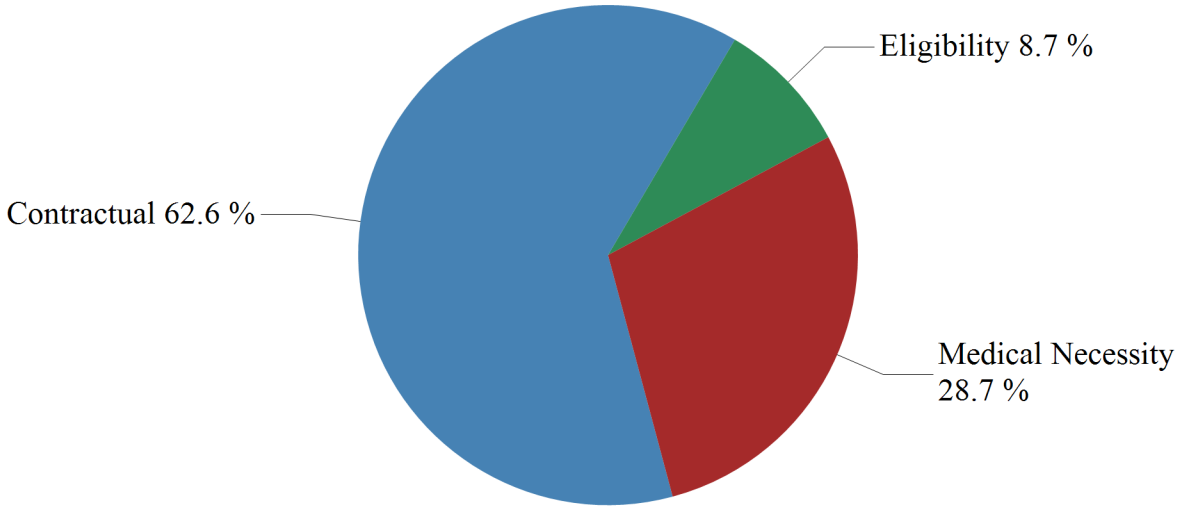
The chart below reflects the outcomes of the 712 Appeals and Grievances cases the HEAU mediated and closed during FY 2018 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

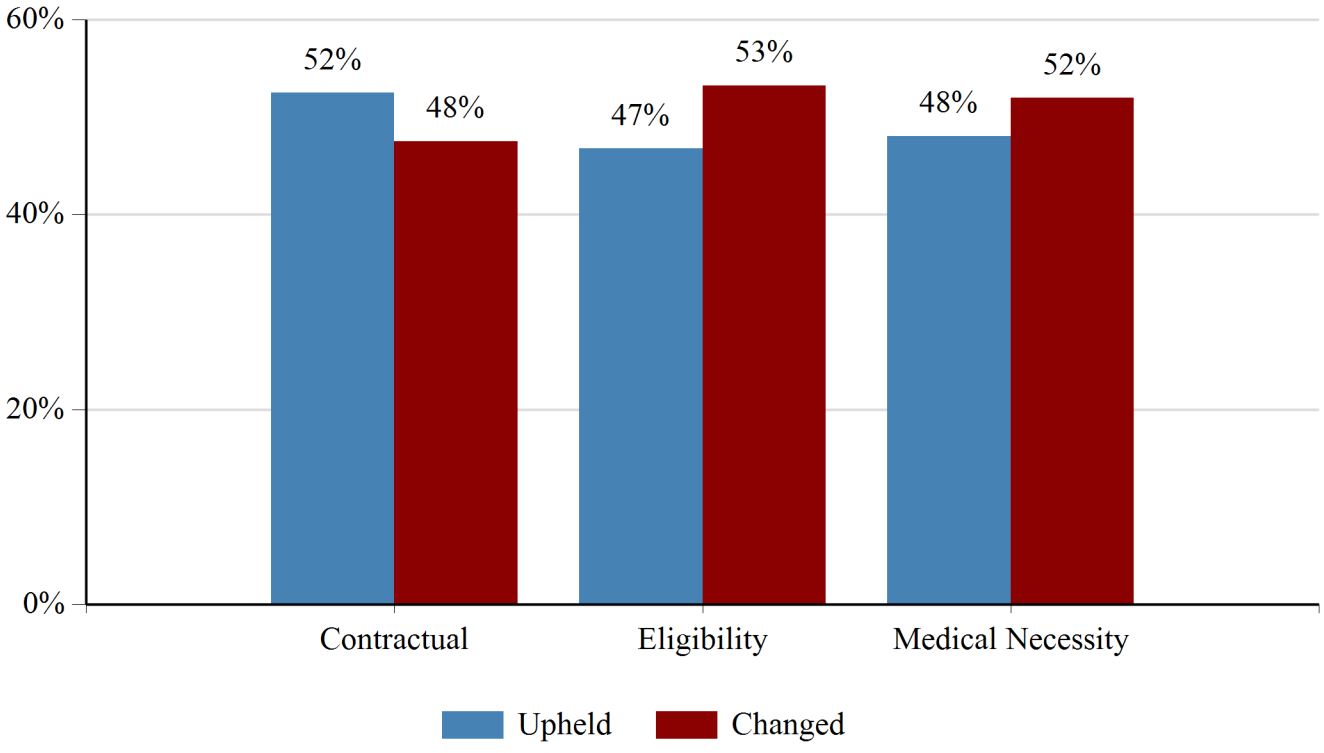
Types of Denials

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 2018.



Outcomes by Denial Type

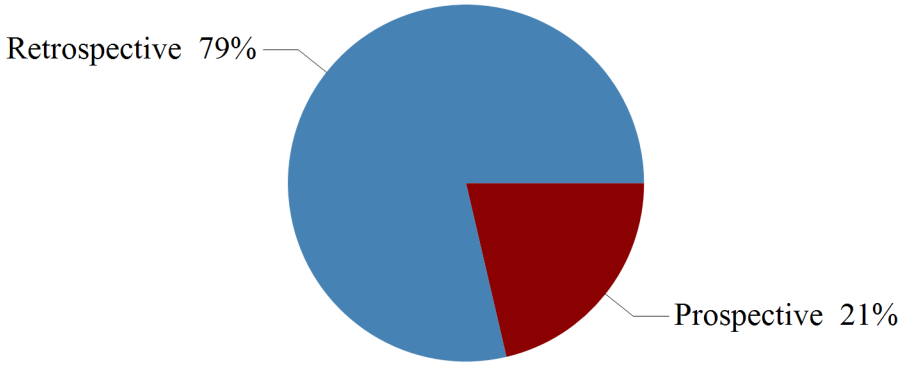
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2018.



HEAU Mediated Appeals and Grievances Cases

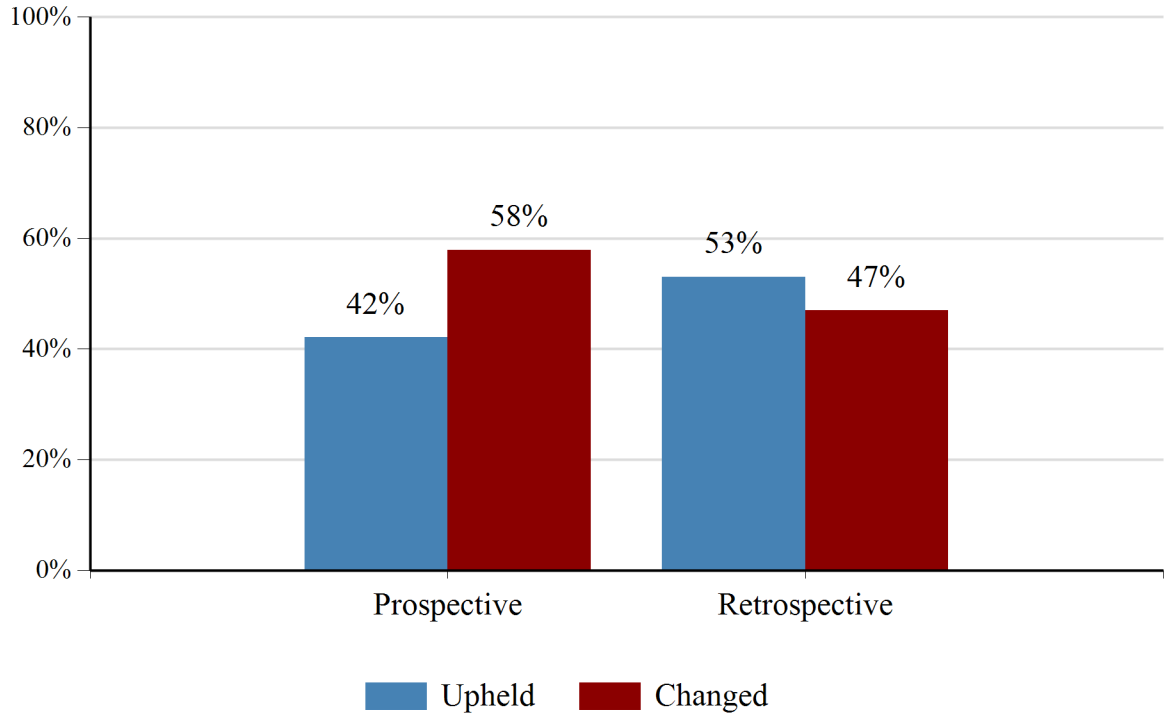
Timing of Denials

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 2018. Eligibility disputes are treated as prospective denials.



Outcomes by Timing of Denials

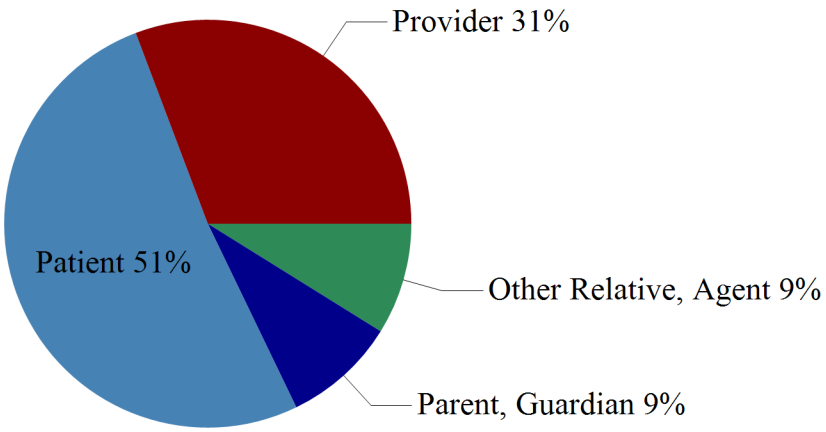
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2018 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

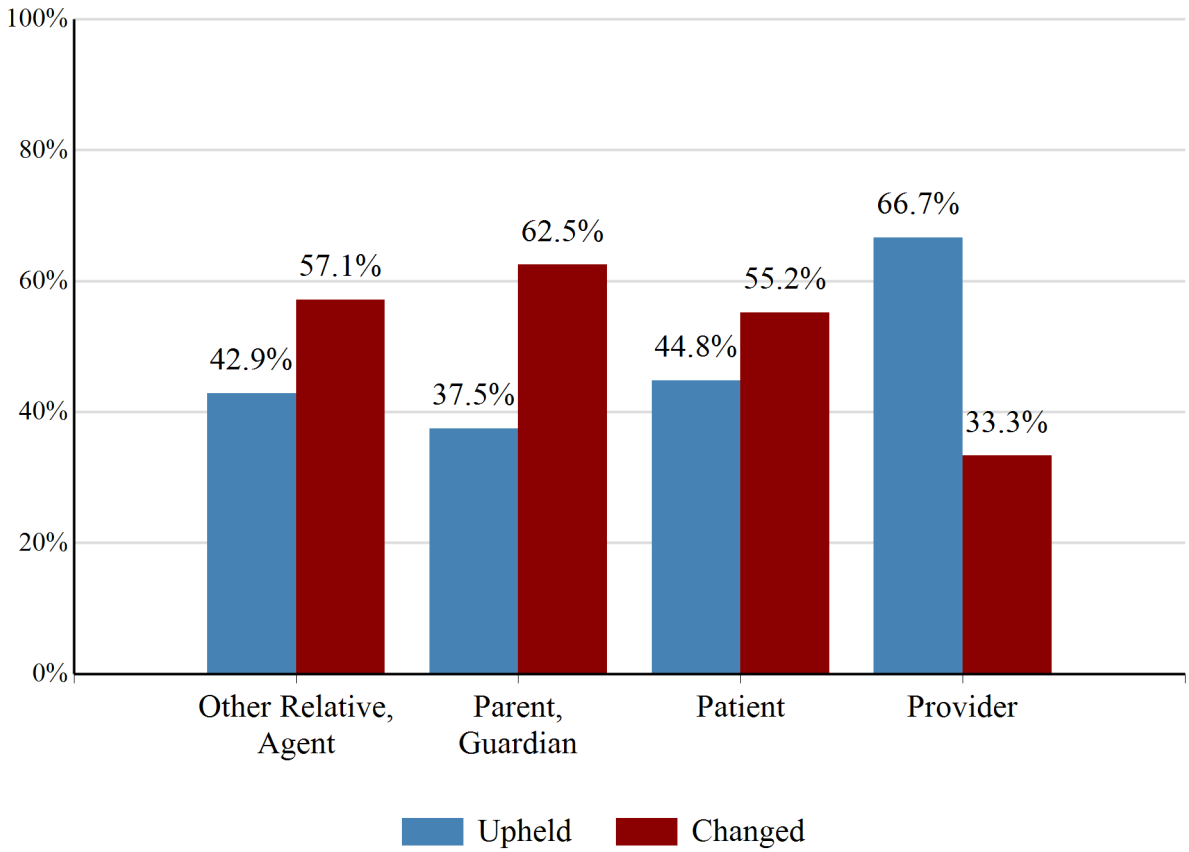
Who Filed the Case

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 2018.



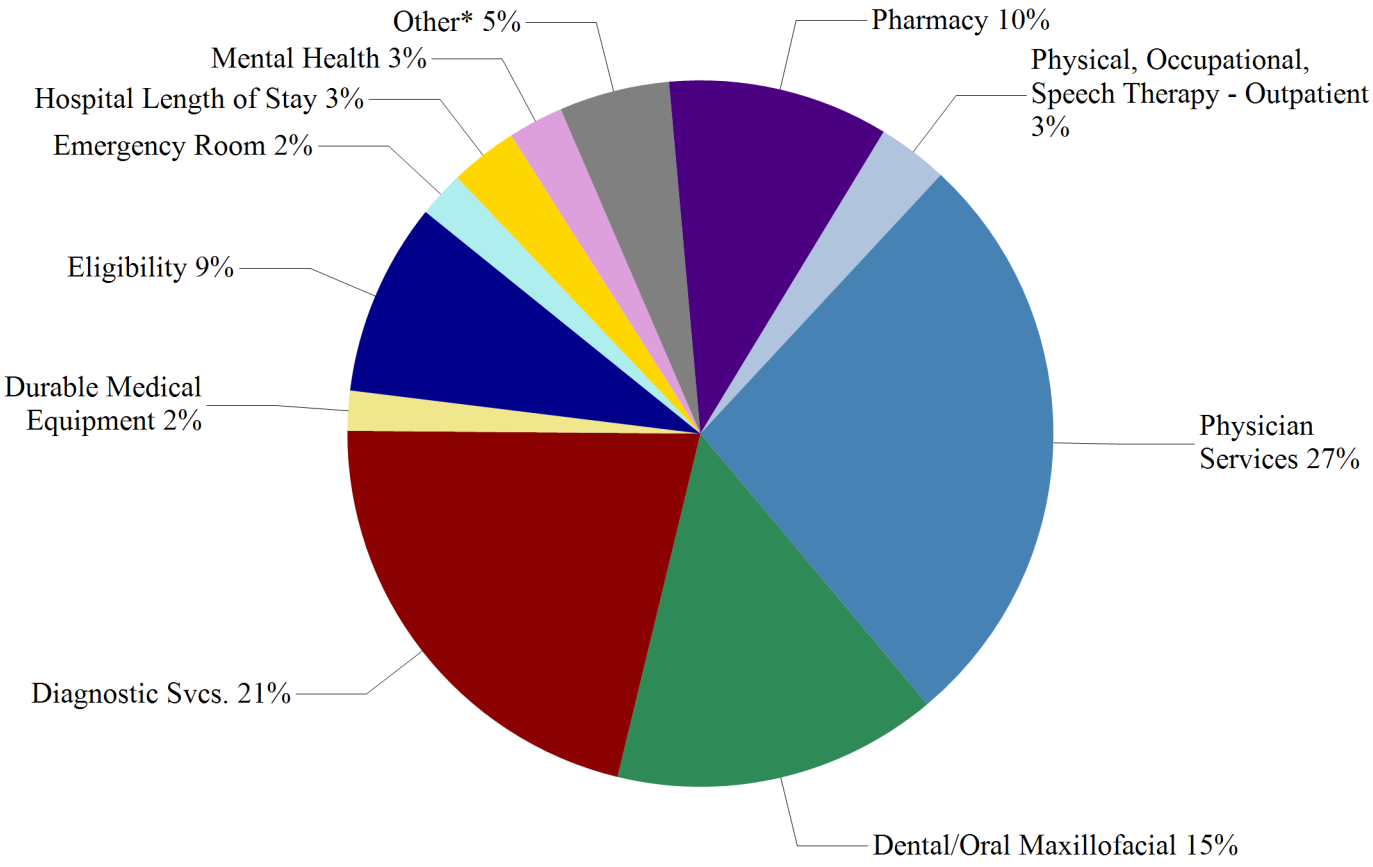
Outcomes by Who Filed the Case

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 2018.



HEAU Mediated Appeals and Grievances Cases
Types of Services Denied

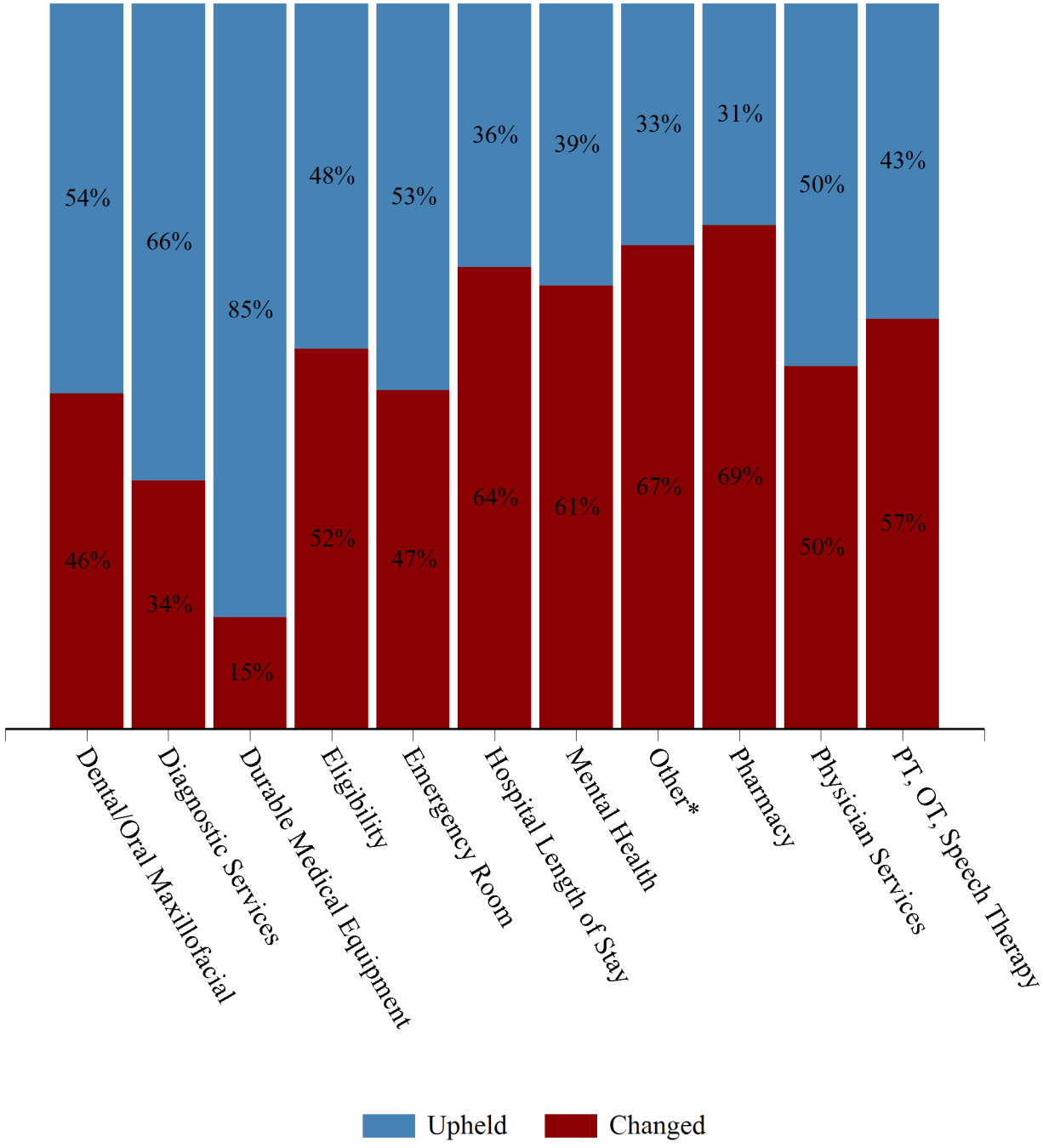
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2018.



* "Other" includes acupuncture, chiropractic, home health, optometry, skilled nursing facility, substance abuse, transport, and other non-specific categories (e.g. birthing class).

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 2018 based on the types of services denied.



* "Other" includes acupuncture, chiropractic, home health, optometry, skilled nursing facility, substance abuse, transport, and other non-specific categories (e.g. birthing class).