State of Maryland
OFFICE OF THE ATTORNEY GENERAL

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# ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

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HEALTH EDUCATION AND ADVOCACY UNIT
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Submitted to the Governor and General Assembly
Insurance Article §15-10A-08
Commercial Law Article §13-4A-04

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Fiscal Year 2024 (Revised)

## 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 and complaint processes available to members, and to include in its annual summary report the results of this evaluation and any proposed changes the HEAU considers necessary.

This report covers grievances and complaints filed or referred during State Fiscal Year 2024, beginning July 1, 2023, and concluding June 30, 2024.

This report (1) summarizes the Appeals and Grievances Law; (2) discusses how health insurance carriers, the MIA, and the HEAU implement the Appeals and Grievances Law; (3) summarizes grievances and complaints handled by carriers, the MIA and the HEAU; and (4) provides additional information about HEAU activities and legislative recommendations to strengthen consumer protections in the health care marketplace.

## II. Overview of the Appeals and Grievances Process

*State Law*

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

In 2000, the General Assembly enacted Chapter 371[3] that expanded the grievances process to include the right to appeal contractual "coverage decisions." As a result, patients in Maryland who have coverage from a State-regulated plan can challenge any decision by a carrier that results

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

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

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

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 in the rescission of an individual's coverage.

In 2023, the General Assembly enacted Chapter 229[5] to implement section 110 of the federal No Surprises Act, requiring among other things, beginning not later than January 1, 2023, that the external review process apply with respect to any adverse determination by a plan or issuer under PHS Act section 2799A–1 (preventing surprise medical bills for out-of-network emergency services and services by out-of-network providers at in-network facilities) and 2799A–2 (ending surprise air ambulance bills).

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

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

*Federal Law*

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

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

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

3. appeal 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

[4] Chapters 3 and 4 made other changes to processes and rights under the Appeals and Grievances Law that became effective July 1, 2011.
[5] Md. Code Ann., Insurance §15-146(b)(application of No Surprises Act)-(d)(MIA No Surprises Act enforcement authority).

[6] 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 23, 2010).
[7] 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS)(July 26, 2011).

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.

In October 2021,[8] HHS, Labor, Treasury, and the Office of Personnel Management (OPM) issued Interim Final Rules amending the 2015 final rules to implement section 110 of the No Surprises Act.

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

## III. Phases of the Appeals and Grievances Process

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

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

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

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

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

## IV. Carrier Reporting

The Appeals and Grievances Law requires carriers to submit quarterly reports to the MIA on the number of adverse decisions issued and the number and outcomes of internal grievances. The MIA then forwards this data to the HEAU for inclusion in this report. Until recently, however, the carriers were not required to report on total enrollee numbers or total claims processed, so no relational analysis of the data was possible. House Bill 1337, Chapter 891, Acts of 2024, updated the reporting requirements to include (1) the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by the carrier (i.e., "enrollee numbers"); and (2) the number of clean claims for reimbursement processed by the carrier (i.e., "clean claim numbers"). The MIA released the updated form and instructions to carriers in Bulletin 24-21. The first quarter of new reporting data (July 1, 2024 - September 30, 2024) should be available later this year and data collected for each quarter of FY 2025 will allow additional analysis for inclusion in next year's report.

House Bill 932, chapter 847, Acts of 2024 also updated the carrier reporting requirements, effective January 1, 2025, to include (1) whether the adverse decision involved a prior authorization or step therapy protocol; (2) the number of adverse decisions overturned after a reconsideration request; and (3) the number of formulary exception requests made and outcome.

While the data the carriers are required to provide is still somewhat limited in HEAU's view (*see*, HEAU Annual Report FY 2023, page 4), the addition of enrollee and clean claim
numbers will help ensure carrier accountability under the Appeals and Grievances Law and the data regarding prior authorization or step therapy protocol and formulary exception requests will provide valuable insight on how those claims are ultimately processed.

What the current data does reveal is that in the last ten fiscal years, on average **only 10 percent of adverse decisions are challenged**, and on average, **54 percent of those grievances are reversed**. Given the low number of grievances filed and the percentage of positive outcomes that occur when a grievance is filed, efforts are underway to help consumers understand their grievance rights and to encourage them to file, seeking HEAU's help when needed. A workgroup co-led by the MIA and HEAU is currently meeting with carriers and consumer advocates to discuss ways in which to encourage consumers to request review of their denied claims, including modifications to the denial notice itself to make the notice of rights more prominent.

*Carrier Statistics FY 2024*

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

1. Carriers reported 113,251 adverse decisions in FY 2024, 22,671 fewer adverse decisions than reported in FY 2023.

2. In FY 2024, consumers filed 11,466 grievances, challenging only 10% of the adverse decisions.

3. As with FY 2023, the largest percentage of grievances filed were in the pharmacy (50%), dental (17%), lab/radiology (14%), and physician (6%) service categories.

4. Overall, in FY 2024, during the internal grievance process, carriers overturned or modified 54% of their original adverse decisions.

5. Adverse decisions involving mental health/substance abuse services continue to be overturned or modified infrequently. In FY 2024, carriers reported an overturned or modified rate of 28% for mental health and substance abuse services.

6. In FY 2024, 50% or more of the pharmacy (62%) and dental (53%) adverse decisions grieved were overturned or modified.

## V. Maryland Insurance Administration (MIA)

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

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

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

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 then forwarded to an Independent Review Organization ("IRO") for a medical necessity review via the IRO's electronic portal. 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 written determination via 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 via electronic mail, U.S. mail, or facsimile. The MIA also forwards a copy of the IRO's medical opinion to the carrier via the MIA's licensee portal. In all instances, the carrier that is the subject of the complaint must pay the expenses of the IRO selected by the MIA. Hearing rights to contest the MIA decision are given to all consumers, except for individuals covered under the State of Maryland employee/retiree plan. Carriers do not have a right to an administrative hearing but may file a petition for judicial review.

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

*MIA Statistics FY 2024*

MIA-provided data are reported on the charts and tables contained on pages 25-31 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 1,000 complaints in FY 2024. After reviewing these complaints, the MIA determined that 414 involved MIA-regulated adverse decisions.

2. The MIA referred 46 consumers to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.[11]

3. The MIA investigated 368 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 256 cases (70%). The MIA upheld 112 (30%) of the carrier's initial decisions.

4. Like FY 2023, the largest percentages of grievances filed involved pharmacy services/formulary issues (41%); lab, imaging, and test services (28%); physician services (11%); and dental care (6%).

## VI. Health Education and Advocacy Unit

The Maryland General Assembly established the Health Education and Advocacy Unit (HEAU) in 1986. The HEAU was designed to assist health care consumers understand health care bills and third-party coverage, to identify improper billing or coverage determinations, to report billing or coverage problems to appropriate agencies, including the Consumer Protection Division's Enforcement Unit, and to assist patients with health equipment warranty issues. Based upon the HEAU's successful efforts in these areas, the General Assembly selected the HEAU to be the State's first-line consumer assistance agency when it passed the Maryland Appeals and Grievances Law. Following passage of the ACA and the implementation of Maryland's Health Benefit Exchange, the HEAU began helping consumers who encountered problems enrolling on the Exchange and with obtaining premium tax credits and cost-sharing reductions.

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

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

[11] In prior years the MIA referred failure to exhaust internal appeal complaints and complaints where the MIA did not have jurisdiction directly to the HEAU for processing. Beginning in September 2023, consumers were directed to the HEAU without a file transfer, decreasing the workload for both the MIA and the HEAU. Full files were transferred on request.

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 2024*

The HEAU Appeals and Grievances data[12] are reported in the charts and tables contained on pages 32-47 of this report. The data reflect medical necessity, contractual, and eligibility denials. Because newly filed cases contain incomplete data, this report includes only those cases the HEAU closed during FY 2024.

The HEAU closed 1,949 cases in FY 2024.

1. 41% of the complaints closed by the HEAU involved "carriers" defined in this report to include insurers, nonprofit health service plans, HMOs, dental plan organizations, third-party administrators, utilization review agents, pharmaceutical benefit management companies, and any other entity that provides health benefit plans or adjudicates claims.

2. 11% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection-related issues.

3. 694 of the complaints closed by the HEAU were cases involving appeals and grievances. Not all the 694 appeals and grievances complaints filed with the HEAU were mediated. Some consumers, or other persons acting on their behalf, file complaints but never complete an authorization to release medical records form or an authorized representative form (for Maryland Health Connection cases), which the HEAU requires to mediate the case. Other complaints are filed for the record only or are referred to a more appropriate agency. Of the 694 appeals and grievances cases the HEAU closed during FY 2024, 384 (55%) involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 384 cases involved more than one carrier.

4. Of the 384 appeals and grievances cases the HEAU mediated during FY 2024, 30% were adverse decision (*medical necessity*) cases, 54% were coverage decision(*contractual exclusion*) cases, and 16% were eligibility cases.

5. As a result of the HEAU mediation process, 55% of the medical necessity cases, 45% of the coverage decision cases, and 51% of the eligibility denial cases were overturned or modified.

6. HEAU mediation efforts resulted in a decision change in 54% of the cases involving at least one MIA-regulated plan. In cases involving non-regulated plans, the HEAU's efforts resulted in a decision change 45% of the time.

[12] 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.

7. In FY 2024, the HEAU assisted patients in recovering or saving over $5.4 million dollars, including over $4.8 million in appeals and grievances cases.

*B. Appeals and Grievances Successes*

Consumers continue to receive significant benefits from Maryland's Appeals and Grievances Law and HEAU assistance. When carrier denials were challenged by the HEAU, 49% were overturned or modified during the reporting period. Positive results for the consumers who reach HEAU notwithstanding, this reversal rate suggests carriers are inappropriately denying claims in the first instance, and the resulting delays burden consumers medically, financially, and emotionally.

Some examples from cases mediated by the HEAU this year highlight the importance of consumer assistance when challenging claim payment avoidance by insurers and health care claim denials.

1. An insurance carrier retroactively denied a cycle of physical therapy treatment (dry needling for a musculoskeletal condition), claiming it was experimental or investigational, even though the treatment is considered safe and effective by the medical community and was deemed medically necessary for the consumer by his own treating provider. It was the only treatment that had provided the consumer any relief, decreasing pain and increasing range of motion. The insurance carrier upheld the denial on internal appeal. With HEAU's assistance, the claim was submitted to an external reviewer. The denial was overturned, allowing reimbursement for the thirteen visits that had provided the consumer with significant relief.

2. An insurance carrier prospectively denied a spinal surgery, deeming the proposed surgical approach as not medically necessary. The carrier wanted the spinal surgeon to use an older methodology, which the spinal surgeon stated he had not used in over a decade. The older methodology used cadaver bone as a spacer between spinal vertebrae. According to the provider, cadaver bone has been documented to be a source of infection and he cited a 2021 outbreak of tuberculosis linked to contaminated bone graft product. The newer methodology uses cervical cages, rather than cadaver bone. The denial was upheld on two levels of appeal internal to the insurance carrier. Once submitted externally to an Independent Review Organization, the denial was overturned, authorizing the methodology preferred by the spinal surgeon and by the consumer.

3. A consumer reached out to the HEAU because although he had health insurance, his primary insurer avoided paying the claims because it insisted on processing the claims as though the plan were secondary, when it was not. The made many attempts to get relief from the customer service department but kept getting redirected to the coordination of benefits department. After more than 5 attempts with the coordination of benefits department, he did not receive a satisfactory response or receive any return calls from anyone who purportedly could help. He then began receiving provider bills

for six months of services. His providers started refusing future treatment if the bills weren't paid. The HEAU was able to resolve the issue by having the claims processed correctly, saving the consumer $2,500, an enormous amount of frustration, and granting him access to the care he needed.

4. In a case involving the coordination of benefits, the secondary insurer paid claims but later clawed back the payments and then billed the consumer tens of thousands of dollars. Although the consumer tried for nearly a year to resolve the error and to have the claims properly paid, she was unsuccessful. The HEAU worked through each claim, insisting on proper processing, and was successful in obtaining appropriate payment, relieving the consumer of having to pay bills for which she had unfairly been held responsible.

5. A consumer had surgery to repair a broken right clavicle, with an expected out-of-pocket expense of $5,000. During the surgery the consumer sustained a torn vein complication requiring an unexpected vascular surgeon to join the surgical team and an extension of the surgical time. The insurance carrier denied the vascular surgery portion of the claim and specifically instructed the hospital to send the bill of $43,000 directly to their insured. The HEAU appealed this decision with the reviewing entity which agreed the surgery was medically necessary and the insurer should pay. Despite the decision, it took the insurer more than a year to pay the claim. During this time, HEAU monitored the situation to ensure no further bills would be sent to the consumer. After 15 months, the insurer finally paid.

6. A consumer had dental claims rejected for not having satisfied the waiting period for implants/crowns. The consumer had been continuously covered and called and wrote to the insurer 10 times to correct the waiting period rejection. She then contacted HEAU for assistance, and the insurer paid the claims.

7. A child was born at an in-network hospital but was seen by an out-of-network pediatrician. The insurer processed the pediatrician's claim as an out-of-network service, applying out-of-network cost sharing. When the family contacted the carrier, they were told the claim was not covered under the federal No Surprises Act. HEAU appealed, and the insurer overturned the denial, acknowledging the situation was clearly covered under the No Suprises Act. The claim was reprocessed, significantly reducing the consumer's cost-sharing responsibility.

8. Every year for the past five years, a consumer has reached out to the HEAU because her yearly prior authorization for needed medication was denied. Each year the HEAU appeals the denial and is forced to send supporting medical records and the approvals from the previous years. Each year the medication is approved after appeal. This case is just one of many examples where the insurer insists on making the consumer (and provider) prove repeatedly – even after 12 years of continuous use – that the prescribed medication is necessary and effective in treating the consumer's disease or medical condition.

9. A consumer underwent a pre-approved cardiac procedure and, because of a coordination of benefits dispute, was shocked when he was billed $20,700 by the hospital for an amount that exceeded his plan's out-of-pocket maximum. He paid the bill with a credit card out of fear of incurring late fees, but then incurred credit card fees on the card balance. The consumer was so worried that he delayed additional recommended treatment until the dispute could be resolved. The primary insurer initially avoided paying the claim, insisting the coverage was secondary to Medicare, but it was not, it was the primary insurance plan. The HEAU appealed and the carrier reversed, paying the hospital claim with interest. The consumer was issued a refund of his overpayment.

10. A consumer was referred to an ophthalmologist for blepharoplasty/revision of upper eyelids. She suffered from constant and progressive eyelid inflammation and loose eyelid skin, and visual field studies conducted by her physician demonstrated 30% visual impairment, which met the guidelines for surgery. However, the carrier denied the provider's pre-authorization request, deeming the surgery cosmetic, and thus falling under an exclusion to benefits under her plan. The HEAU successfully appealed the decision; the surgery was authorized, saving the consumer $5,600 in out-of-pocket costs.

These examples demonstrate the value of HEAU's assistance when consumers obtain it, but mediation continues to be a back-end solution. Health claim denials, particularly when unwarranted, harm consumers by delaying necessary care, risking consumer health and the financial stability of their households. These concerns deserve front-end solutions such as the Health Insurance Utilization Review bill (HB932/SB791) passed by the General Assembly in the 2023 session. It is too soon, however, for HEAU to report on the legislation's actual effect on the number and type of denials that it sees.

### *C. Additional HEAU Activities and Data*

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

In FY 2024, categories in which the HEAU received the largest number of non-appeals-related cases were:

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

- Termination – Failure to Terminate
- Enrollment - APTC/CSR Dispute

The HEAU continues to monitor and offer consumer-centric input to State agencies involved in health policy decision making. The HEAU's director or deputy director served as a consumer representative, either as a member or in an *ex officio* capacity, on the Maryland Health Benefit Exchange's Standing Advisory Committee and Maryland Easy Enrollment Workgroup; the Maryland Health Care Commission's Health Information Exchange Advisory and Nursing Home Acquisitions Workgroups; the Protected Health Care Commission; the Health Insurance Utilization Review Workgroup; and the Health Services Cost Review Commission's Hospital Payment Plan Guideline and Medical Bill Reimbursement Process Workgroups.

The HEAU also provided consultative and litigation support to the Office of the Attorney General in its efforts to advance and defend the consumer protections afforded to Marylanders by the Affordable Care Act and other federal laws and joined amicus briefs and commented on federal and State regulations supporting efforts to enhance consumer protections in the health care marketplace.

*D. Areas of Concern*

1. Hospital Facility Fees

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

a. Diagnostic Radiology, Ultrasound, and Vascular
b. Nuclear Medicine
c. Radiology Therapeutic
d. Electrocardiography
e. Electroencephalography
f. Physical Therapy & Occupational Therapy
g. Respiratory Therapy & Pulmonary Function Testing
h. Leukopheresis
i. Labor and Delivery
j. Interventional Radiology/Cardiovascular
k. Ambulance Services – Rebundled
l. Speech Therapy
m. Audiology
n. Laboratory Services
o. CT/MRI

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

Accordingly, during the 2024 session, the OAG sought legislation requiring that statutory notice be provided for facility fees billed in the rate centers outlined above and by out-of-state hospitals billing facility fees in Maryland outpatient settings. As a result, the HEAU is participating in a HSCRC-led workgroup established by SB 1103 that will report further on expanding statutory notice requirements at the end of this year, and provide research on the impact, purpose, and feasibility of continued facility fee charges in a subsequent report due at the end of 2025. Pursuant to the General Assembly's directive in Section 3(b) of Session Laws Ch. 142, the workgroup has been charged with making recommendations this year concerning the expansion of notice. The HEAU believes that consumers who visit hospital outpatient settings should not be blindsided by unexpected charges. Accordingly, the HEAU believes that statutory notice needs to be expanded. This issue has urgency for consumers because the burden of paying the fee out-of-pocket falls disproportionally on underinsured patients, who are least likely to be able to afford it.

2. Other Out-of-Network Facilities

The HEAU continues to receive complaints from consumers who are referred by an in-network provider to an out-of-network facility for services. Consumers receive services at these facilities without realizing that they are out-of-network and have incurred bills much higher than they would have incurred at an in-network facility. Some facilities provide no out-of-network notice, others have consumers sign forms that say the facility might be out-of-network. But consumers sign many forms when they present for services without having the opportunity to carefully read them or having the opportunity to edit them in any way. This is a concern that is expected to be addressed by the Good Faith Estimate, Advanced Explanation of Benefits provisions in the federal No Surprises Act once the regulatory process is complete. The General Assembly might consider offering protections to Marylanders now.

3. Additional Concerns

The HEAU also has concerns about providers who, a) require pre-treatment payments of deductibles and coinsurance; b) fail to refund overpayments; c) fail to provide reasonable refund policies for cancelled appointments; d) refuse to provide service without obtaining a credit card "on file" with authority to charge unspecified amounts; e) fail to provide requested medical records; f) submit claims with incorrect diagnostic codes that result in greater patient cost-sharing; and g) abandon medical records. In addition, the HEAU receives at least one or two complaints a year from consumers who have another person's medical information inserted into their medical record; it is often exceedingly difficult to correct the record. The HEAU continues to receive complaints from consumers unaware of their right to obtain hospital financial assistance and income-based payment plans, including about hospitals setting unrealistic and unaffordable monthly payment plans.

## VII. Conclusion

The Maryland General Assembly continues to advance legislation to protect consumers from unscrupulous behavior in the health care marketplace, often over the objections of some other market participants who seek to maximize profits. The HEAU looks forward to continued partnership with elected officials and others who seek to lead and innovate in the health care marketplace to provide all Marylanders with timely, transparent, affordable, and high-quality care.

Appendix

**Carrier Cases**
**Adverse Decisions, Grievances and Outcomes**

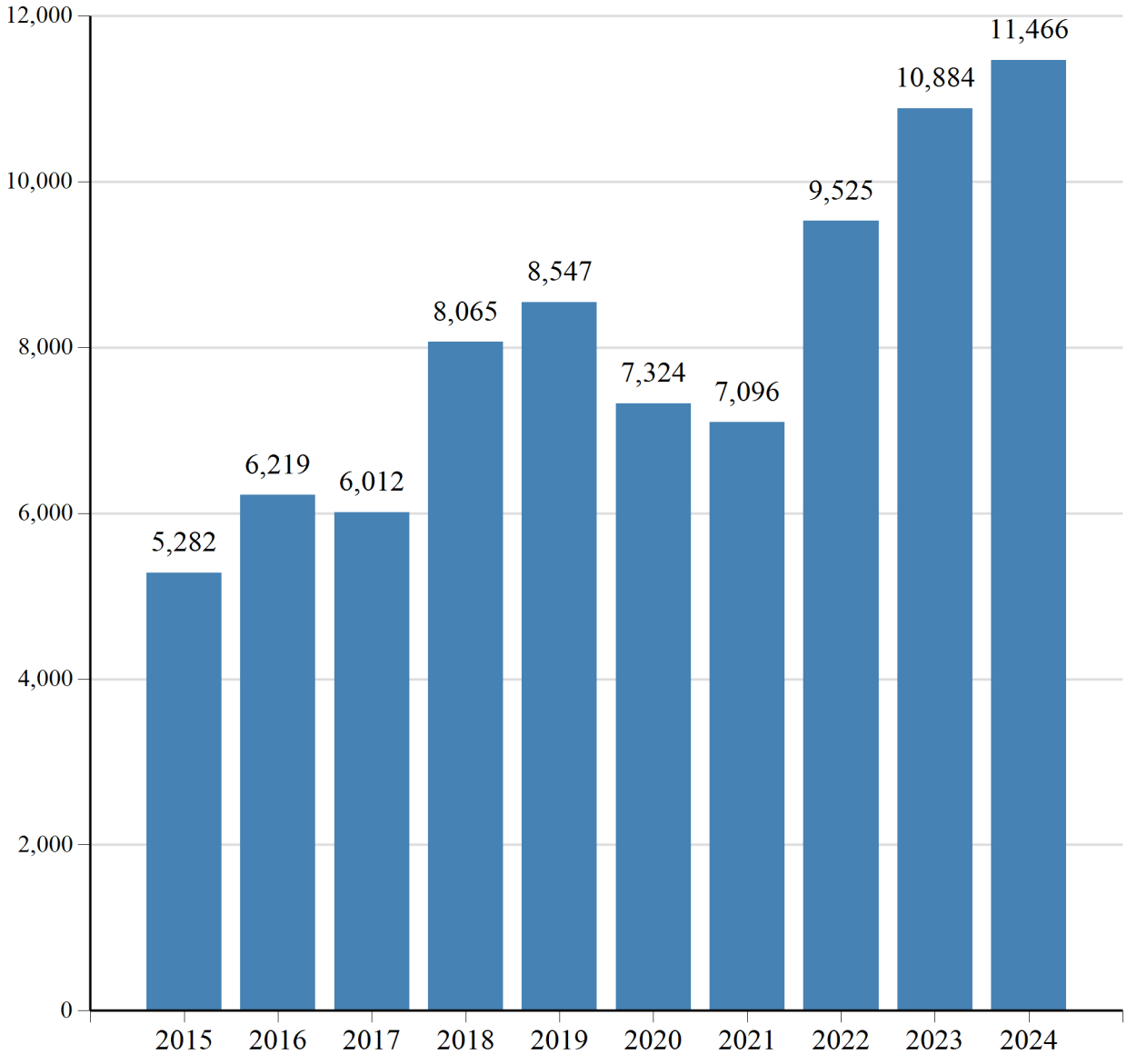
| Carrier | Adverse Decisions | | Grievances Filed & Outcome | | |
|---|---|---|---|---|---|
| | Total Adverse Decisions | Carrier Admin. Reversed | Total Grievances | Upheld | Overturned/ Modified |
| Aetna Dental Inc. | 537 | 0 | 0 | 0% | 0% |
| Aetna Health Inc. ( a Pennsylvania corporation ) | 188 | 19 | 280 | 51% | 49% |
| Aetna Life Insurance Company | 317 | 22 | 294 | 62% | 38% |
| Alpha Dental Programs, Inc. | 0 | 0 | 1 | 100% | 0% |
| Ameritas Life Insurance Corp. | 498 | 0 | 259 | 48% | 52% |
| CareFirst BlueChoice, Inc. | 30,131 | 0 | 3,133 | 47% | 53% |
| Carefirst of Maryland, Inc. | 11,886 | 0 | 1,301 | 37% | 63% |
| Chesapeake Life Insurance Company | 0 | 0 | 1 | 0% | 100% |
| CIGNA Dental Health of Maryland, Inc. | 35 | 0 | 2 | 100% | 0% |
| CIGNA Health and Life Insurance Company | 25,139 | 0 | 763 | 49% | 51% |
| Colonial Life & Accident Insurance Company | 3 | 0 | 0 | 0% | 0% |
| Connecticut General Life Insurance Company | 1 | 0 | 0 | 0% | 0% |
| Delta Dental Insurance Company | 1 | 0 | 5 | 60% | 40% |
| Delta Dental of Pennsylvania | 28 | 0 | 9 | 56% | 44% |
| Dental Network, Inc. | 2 | 0 | 0 | 0% | 0% |
| Dentegra Insurance Company | 0 | 0 | 1 | 0% | 100% |
| Dominion Dental Services, Inc. | 2,672 | 0 | 266 | 66% | 34% |
| Golden Rule Insurance Company | 10 | 0 | 4 | 50% | 50% |
| Group Hospitalization and Medical Services, Inc. | 8,992 | 0 | 1,048 | 42% | 58% |
| Guardian Life Insurance Company of America | 1,373 | 0 | 695 | 47% | 53% |

| Carrier | Adverse Decisions | | Grievances Filed & Outcome | | |
|---|---|---|---|---|---|
| | Total Adverse Decisions | Carrier Admin. Reversed | Total Grievances | Upheld | Overturned/ Modified |
| HealthMarkets Insurance Company | 0 | 0 | 3 | 33% | 67% |
| Johns Hopkins HealthCare LLC | 0 | 0 | 1 | 100% | 0% |
| Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. | 1,854 | 6 | 145 | 73% | 27% |
| Kaiser Permanente Insurance Company | 12 | 0 | 1 | 100% | 0% |
| Lincoln Life & Annuity Company of New York | 3 | 0 | 0 | 0% | 0% |
| Lincoln National Life Insurance Company | 108 | 40 | 0 | 0% | 0% |
| MAMSI Life and Health Insurance Company | 1,118 | 0 | 93 | 41% | 59% |
| Metropolitan Life Insurance Company | 518 | 79 | 62 | 35% | 65% |
| National Health Insurance Company | 1 | 0 | 0 | 0% | 0% |
| Optimum Choice, Inc. | 2,123 | 0 | 1,011 | 55% | 45% |
| Principal Life Insurance Company | 1,105 | 0 | 66 | 70% | 30% |
| Reliance Standard Life Insurance Company | 23 | 0 | 3 | 67% | 33% |
| Standard Insurance Company | 350 | 0 | 56 | 41% | 59% |
| Starmount Life Insurance Company | 3 | 0 | 6 | 83% | 17% |
| Sun Life Assurance Company of Canada | 680 | 0 | 41 | 56% | 44% |
| United Concordia Insurance Company | 456 | 0 | 137 | 32% | 68% |
| United of Omaha Life Insurance Company | 386 | 34 | 0 | 0% | 0% |
| UnitedHealthcare Insurance Company | 21,079 | 0 | 1,627 | 38% | 62% |
| UnitedHealthcare of the Mid-Atlantic, Inc. | 1,214 | 0 | 72 | 44% | 56% |
| Wellfleet Group LLC | 400 | 1 | 80 | 53% | 48% |

| Carrier | Adverse Decisions | | Grievances Filed & Outcome | | |
|---|---|---|---|---|---|
| | Total Adverse Decisions | Carrier Admin. Reversed | Total Grievances | Upheld | Overturned/ Modified |
| Wellfleet Insurance Company | 5 | 0 | 0 | 0% | 0% |
| **Totals** | **113,251** | **201** | **11,466** | **46%** | **54%** |

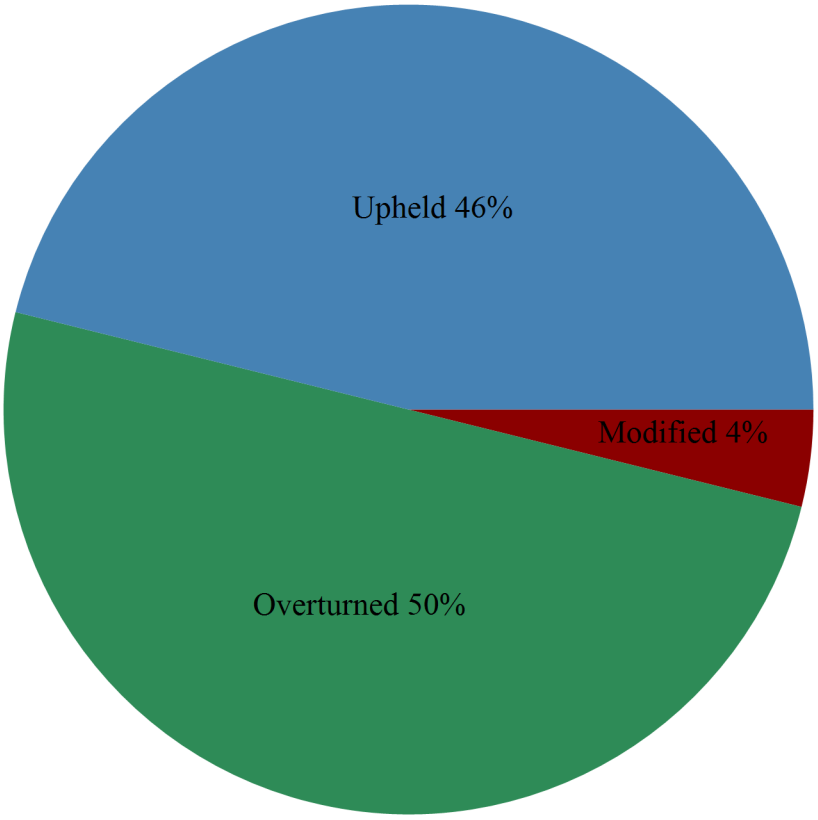
**Carrier Grievances Cases**
**Number of Grievances Over 10 Fiscal Years**

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



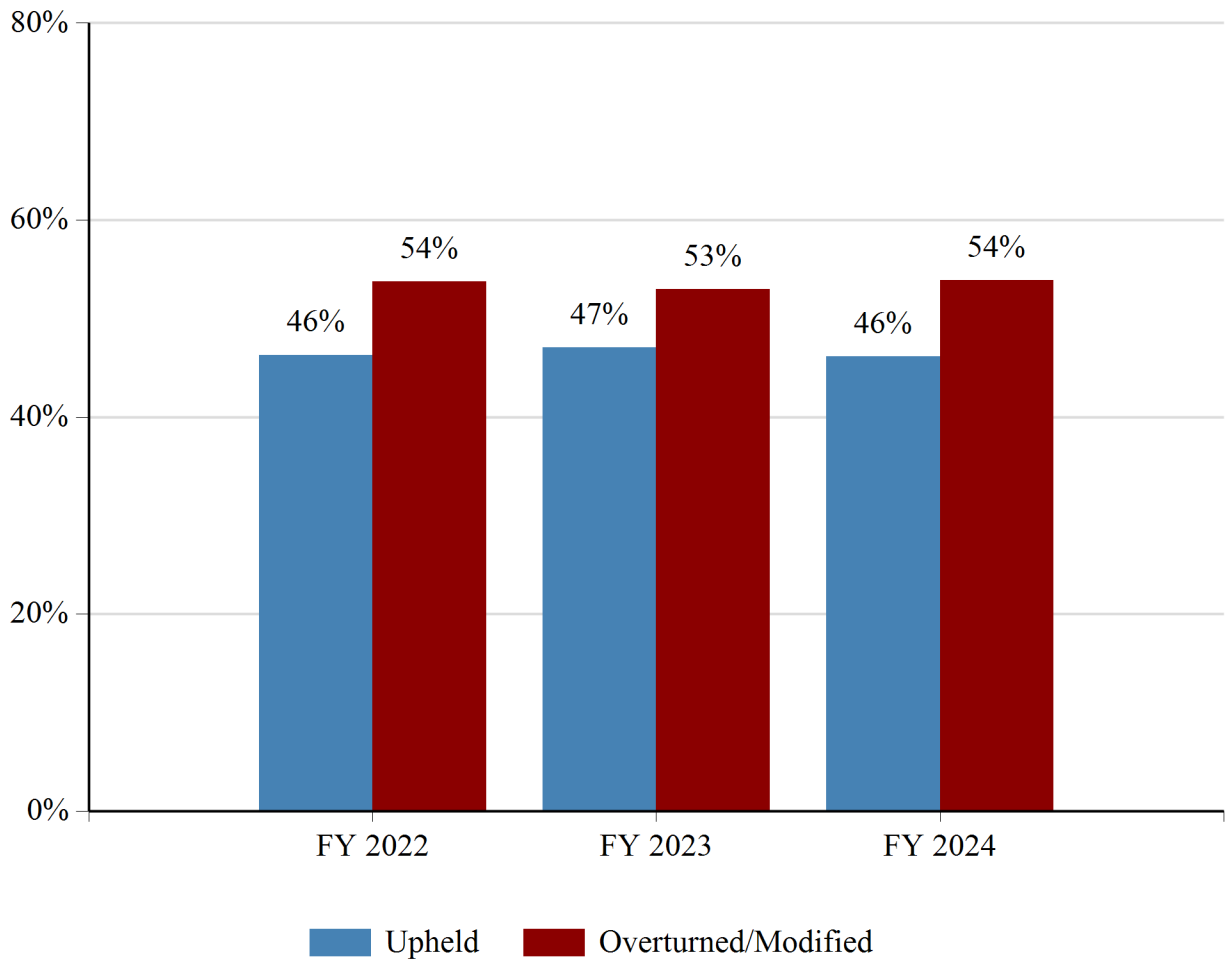
**Carrier Grievances Cases**
**Outcomes**

The chart below describes the outcomes of the 11,466 internal grievances filed with carriers in FY 2024, 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 2024, as reported by carriers.

| Type of Service | Adverse Decisions | | Grievances | |
|---|---|---|---|---|
| Dental | 17,059 | 15.063% | 1,962 | 17.111% |
| Durable Medical Equipment | 1,619 | 1.430% | 197 | 1.718% |
| Emergency Room | 101 | 0.089% | 39 | 0.340% |
| Home Health | 133 | 0.117% | 7 | 0.061% |
| Inpatient Hospital | 1,537 | 1.357% | 139 | 1.212% |
| Laboratory, Radiology | 16,700 | 14.746% | 1,653 | 14.417% |
| Mental Health / Substance Abuse | 718 | 0.634% | 127 | 1.108% |
| Other* | 954 | 0.842% | 724 | 6.314% |
| Pharmacy | 65,703 | 58.015% | 5,772 | 50.340% |
| Physician | 4,377 | 3.865% | 693 | 6.044% |
| PT, OT, ST, including inpatient rehabilitation | 4,150 | 3.664% | 100 | 0.872% |
| Skilled Nursing Facility, Sub Acute Facility, Nursing Home | 200 | 0.177% | 53 | 0.462% |
| **Totals** | **113,251** | **100%** | **11,466** | **100%** |

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

**Carrier Grievances Cases**
**Outcomes by Service Type**

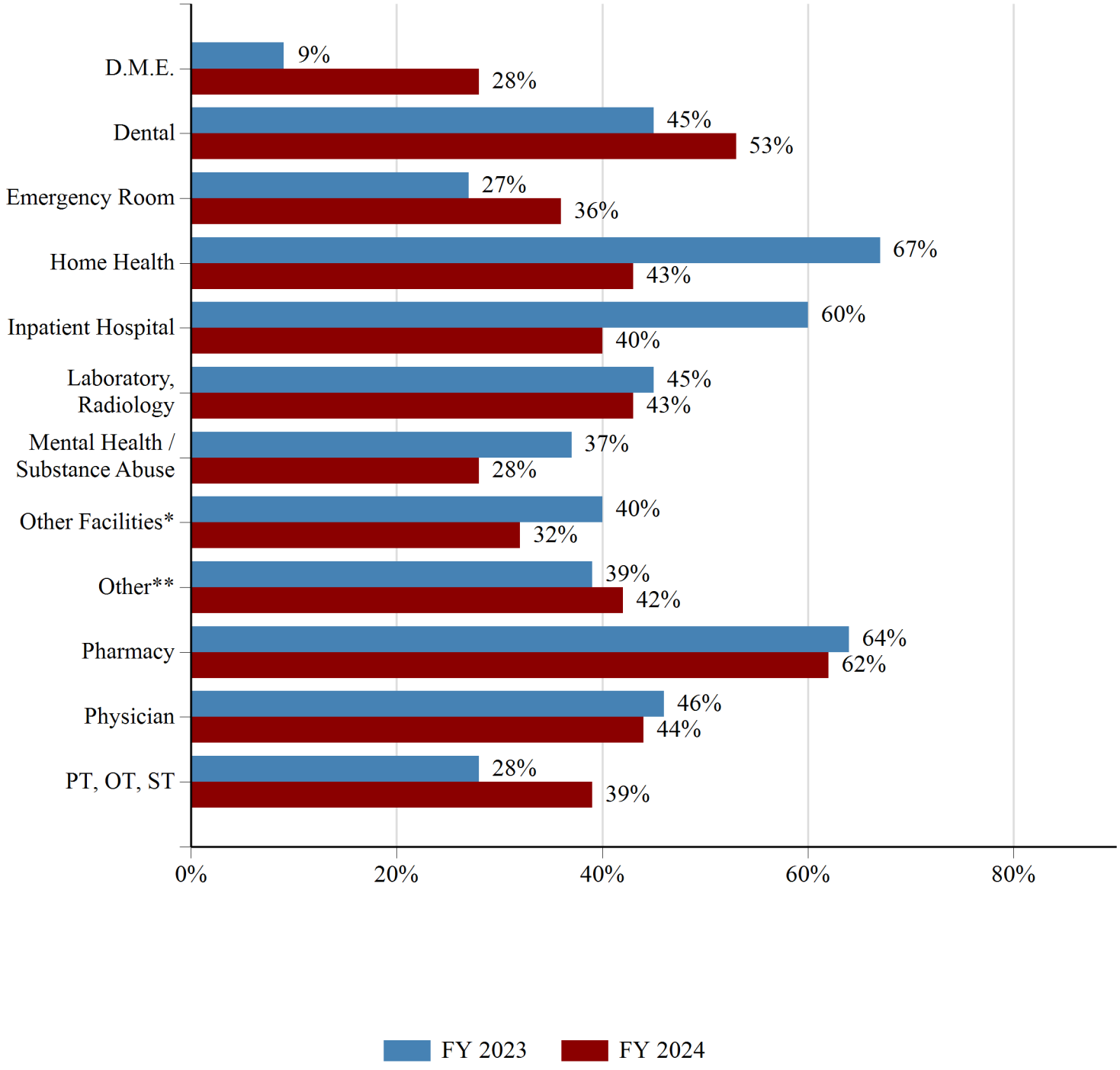
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

| Type of Service | Total Grievances | Upheld | Overturned/ Modified |
|---|---|---|---|
| Dental | 1,962 | 47% | 53% |
| Durable Medical Equipment | 197 | 72% | 28% |
| Emergency Room | 39 | 64% | 36% |
| Home Health | 7 | 57% | 43% |
| Inpatient Hospital | 139 | 60% | 40% |
| Laboratory, Radiology | 1,653 | 57% | 43% |
| Mental Health / Substance Abuse | 127 | 72% | 28% |
| Other* | 724 | 58% | 42% |
| Pharmacy | 5,772 | 38% | 62% |
| Physician | 693 | 56% | 44% |
| PT, OT, ST, including inpatient rehabilitation | 100 | 61% | 39% |
| Skilled Nursing Facility, Sub Acute Facility, Nursing Home | 53 | 68% | 32% |
| **Totals** | **11,466** | **46%** | **54%** |

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

**Carrier Grievances Cases**
**Two Year Comparison by Service Type**

The chart below compares the percentages of grievances carriers overturned or modified by types of services, comparing FY 2023 and FY 2024.

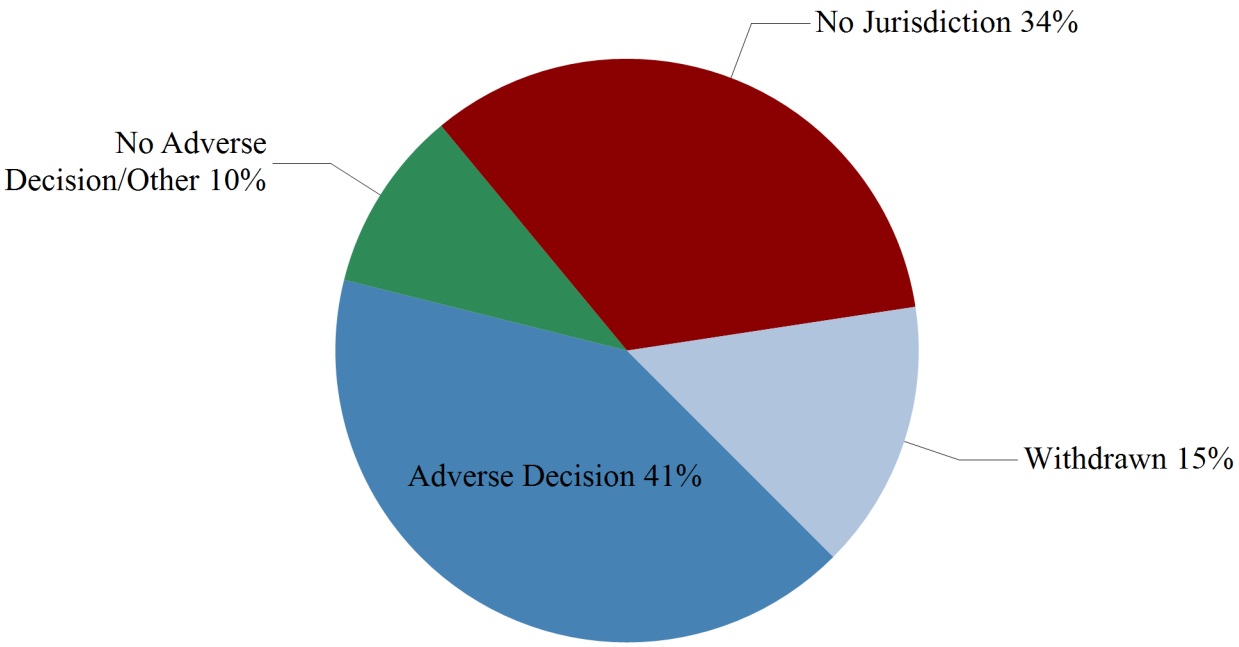



* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.
** "Other" means obesity, IVF, podiatry, hearing and vision.

**MIA Appeals and Grievances Complaints**
**Initial Review of Cases**

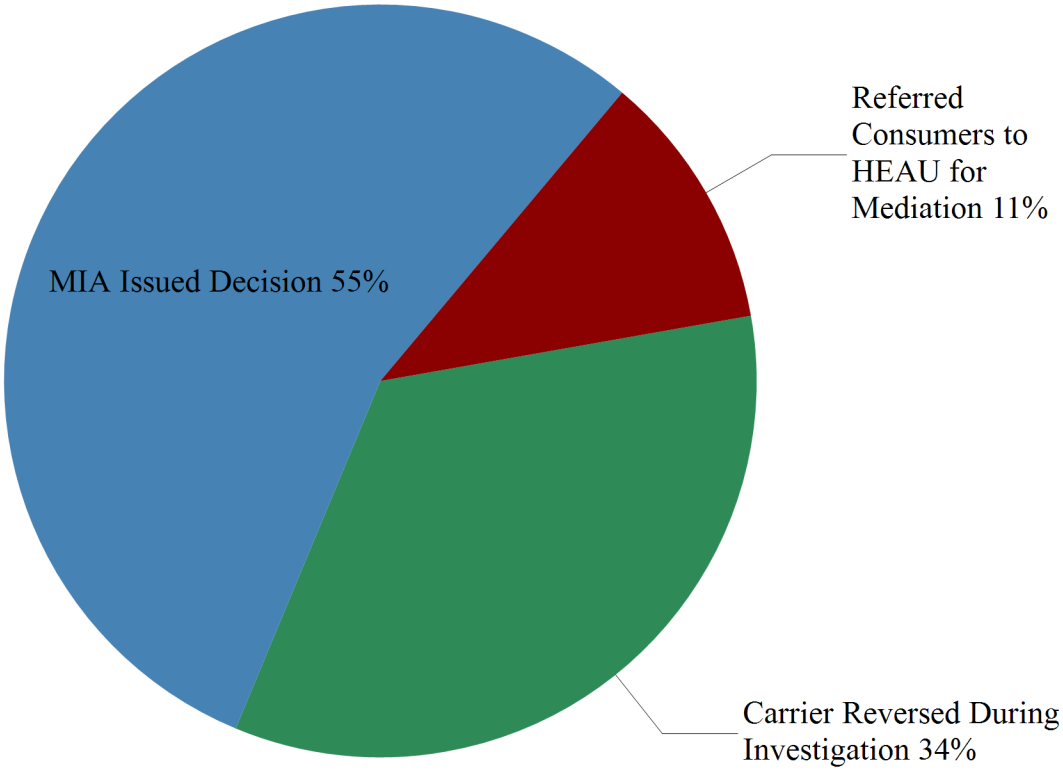
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some 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 1,000 cases filed with the MIA's Appeals and Grievances Unit during FY 2024.



**MIA Appeals and Grievances Complaints**
**Initial Disposition of Grievances**

During FY 2024, the MIA determined that 414 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 46 consumers 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 414 grievances the MIA reviewed during FY 2024.



**MIA Appeals and Grievances Cases**
**Carriers and Disposition**

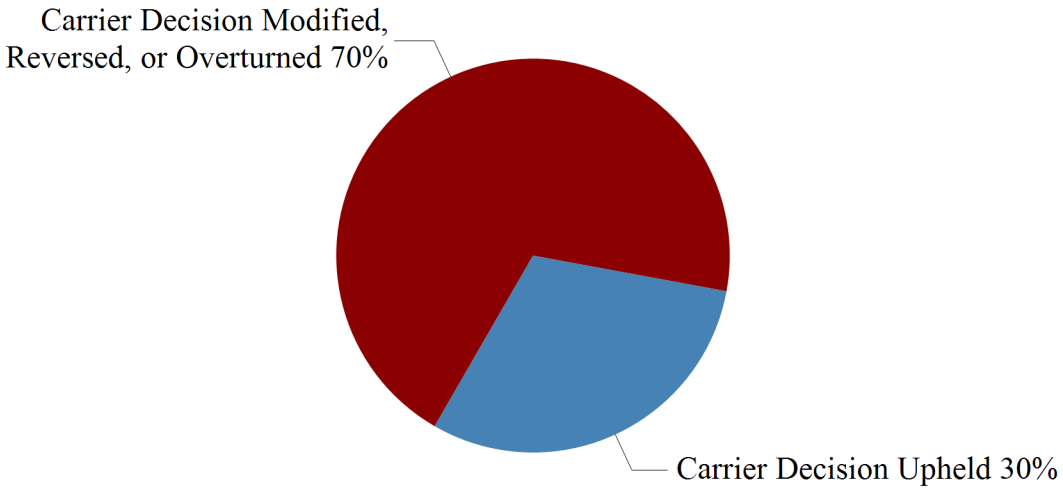
The table below details the outcomes of the 368 grievances complaints the MIA investigated during FY 2024. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

| Carrier | Total Grievances | MIA Upheld Carrier | | MIA Overturned Carrier | | MIA Modified Carrier | | Carrier Reversed Itself During Investigation | |
|---|---|---|---|---|---|---|---|---|---|
| Aetna Health Inc. ( a Pennsylvania corporation ) | 2 | 1 | 50.0% | 1 | 50.0% | 0 | 0.0% | 0 | 0.0% |
| Aetna Health Insurance Company | 5 | 2 | 40.0% | 1 | 20.0% | 0 | 0.0% | 2 | 40.0% |
| Aetna Life Insurance Company | 6 | 0 | 0.0% | 3 | 50.0% | 0 | 0.0% | 3 | 50.0% |
| Ameritas Life Insurance Corp. | 2 | 0 | 0.0% | 0 | 0.0% | 1 | 50.0% | 1 | 50.0% |
| CareFirst BlueChoice, Inc. | 144 | 47 | 32.6% | 53 | 36.8% | 0 | 0.0% | 44 | 30.6% |
| Carefirst of Maryland, Inc. | 71 | 19 | 26.8% | 16 | 22.5% | 0 | 0.0% | 36 | 50.7% |
| CaremarkPCS Health L.L.C. | 1 | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| CIGNA Health and Life Insurance Company | 14 | 5 | 35.7% | 5 | 35.7% | 0 | 0.0% | 4 | 28.6% |
| Delta Dental Insurance Company | 1 | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Delta Dental of Pennsylvania | 1 | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Dominion Dental Services, Inc. | 3 | 0 | 0.0% | 1 | 33.3% | 0 | 0.0% | 2 | 66.7% |
| Golden Rule Insurance Company | 1 | 0 | 0.0% | 1 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Group Hospitalization and Medical Services, Inc. | 23 | 7 | 30.4% | 6 | 26.1% | 0 | 0.0% | 10 | 43.5% |
| Guardian Life Insurance Company of America | 9 | 6 | 66.7% | 0 | 0.0% | 0 | 0.0% | 3 | 33.3% |
| Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. | 9 | 5 | 55.6% | 1 | 11.1% | 0 | 0.0% | 3 | 33.3% |
| MAMSI Life and Health Insurance Company | 3 | 2 | 66.7% | 0 | 0.0% | 0 | 0.0% | 1 | 33.3% |

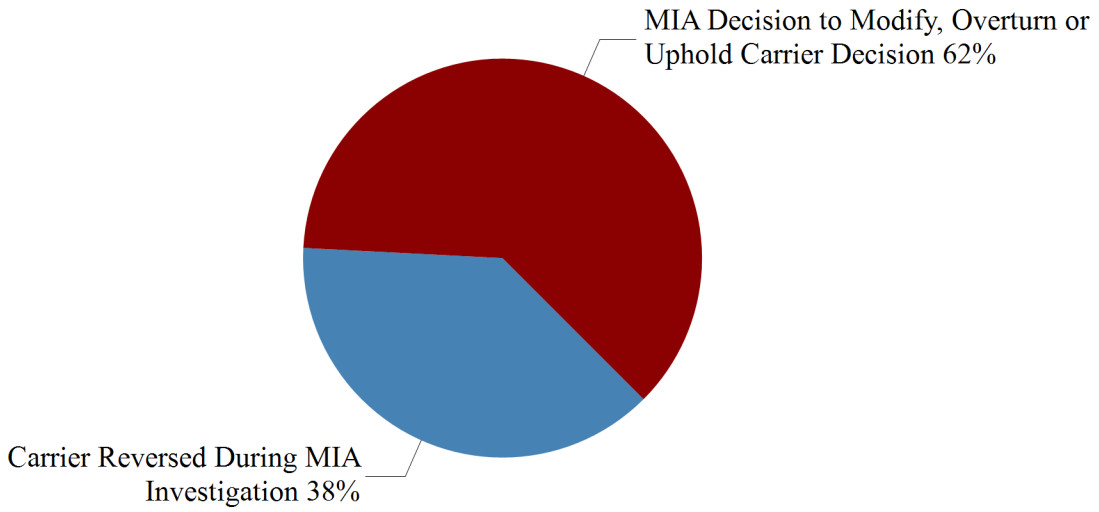
| Carrier | Total Grievances | MIA Upheld Carrier | | MIA Overturned Carrier | | MIA Modified Carrier | | Carrier Reversed Itself During Investigation | |
|---|---|---|---|---|---|---|---|---|---|
| Metropolitan Life Insurance Company | 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% |
| Optimum Choice, Inc. | 7 | 1 | 14.3% | 3 | 42.9% | 0 | 0.0% | 3 | 42.9% |
| Priority Partners MCO. Inc | 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% |
| UnitedHealthcare Insurance Company | 63 | 15 | 23.8% | 21 | 33.3% | 1 | 1.6% | 26 | 41.3% |
| UnitedHealthcare of the Mid-Atlantic, Inc. | 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 100.0% |
| **Totals** | **368** | **112** | **30%** | **113** | **31%** | **2** | **1%** | **141** | **38%** |

**MIA Appeals and Grievances Cases**
**Disposition Following Investigation**

The chart below reflects the overall outcomes of the 368 grievances the MIA investigated during FY 2024.

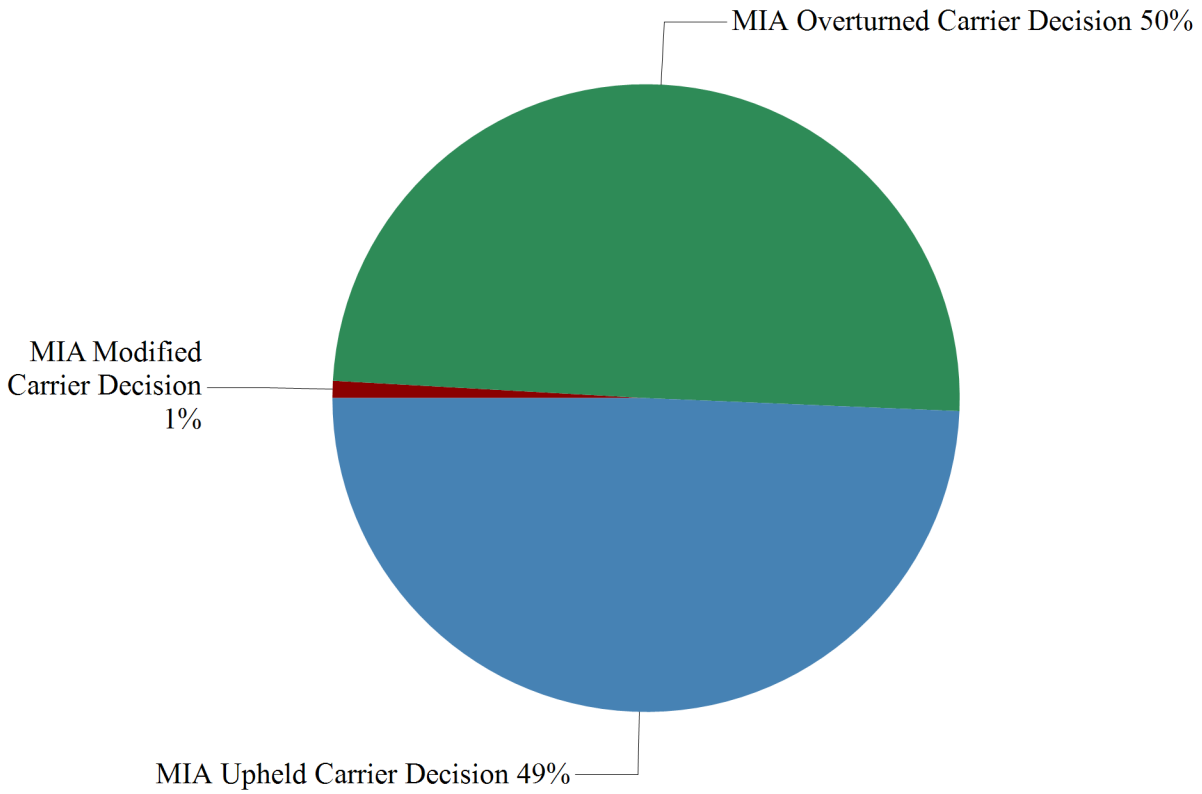



The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



**MIA Appeals and Grievances Cases**
**Disposition Resulting from IRO Review**

The chart below describes the outcomes of the 227 cases the MIA forwarded to an IRO for review in FY 2024.



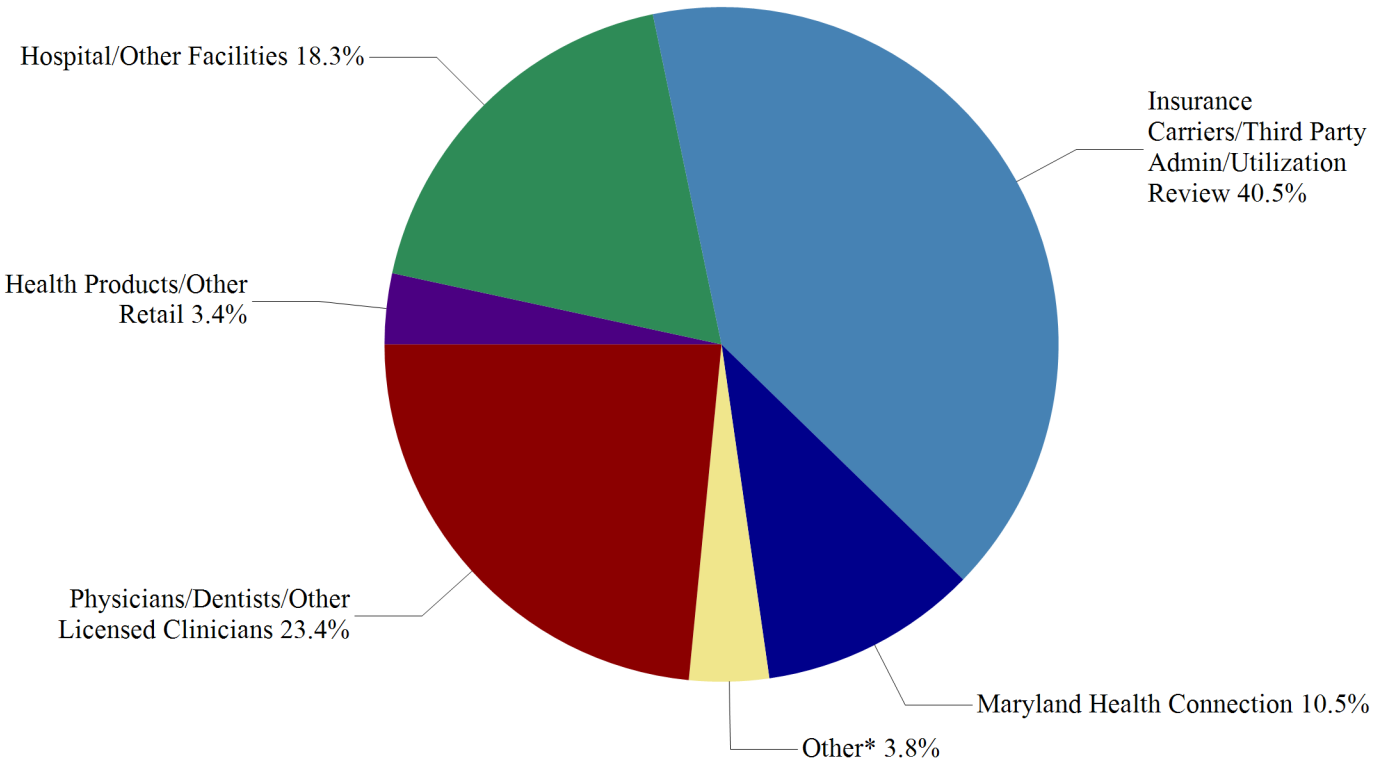
**MIA Appeals and Grievances Cases**
**Types of Services Denied and Outcomes**

The table below identifies the types of services involved in grievances the MIA investigated during FY 2024. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

| Type Of Service | Total Grievances | | MIA Upheld Carrier | | MIA Overturned Carrier | | MIA Modified Carrier | | Carrier Reversed Itself During Investigation | |
|---|---|---|---|---|---|---|---|---|---|---|
| Air Ambulance | 2 | <1 % | 2 | 100% | 0 | 0% | 0 | 0% | 0 | 0% |
| Cosmetic | 4 | 1% | 2 | 50% | 0 | 0% | 0 | 0% | 2 | 50% |
| Denial of Hospital Days | 2 | <1 % | 2 | 100% | 0 | 0% | 0 | 0% | 0 | 0% |
| Dental Care Services | 23 | 6% | 9 | 39% | 1 | 4% | 1 | 4% | 12 | 52% |
| Durable Medical Equipment | 7 | 2% | 4 | 57% | 0 | 0% | 0 | 0% | 3 | 43% |
| Experimental | 8 | 2% | 6 | 75% | 2 | 25% | 0 | 0% | 0 | 0% |
| Eye Care Services | 1 | <1 % | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 100% |
| In-Patient Rehabilitation Services | 4 | 1% | 2 | 50% | 1 | 25% | 0 | 0% | 1 | 25% |
| Lab, Imaging, Test Services | 103 | 28% | 31 | 30% | 59 | 57% | 0 | 0% | 13 | 13% |
| Mental Health/Substance Abuse (Inpatient) Services | 5 | 1% | 0 | 0% | 3 | 60% | 0 | 0% | 2 | 40% |
| Mental Health/Substance Abuse (Outpatient) Services | 7 | 2% | 2 | 29% | 0 | 0% | 0 | 0% | 5 | 71% |
| Opioid Use Disorders | 3 | <1 % | 0 | 0% | 0 | 0% | 0 | 0% | 3 | 100% |
| Outpatient Services | 8 | 2% | 4 | 50% | 3 | 38% | 0 | 0% | 1 | 13% |
| Pharmacy Services/Formulary Issues | 150 | 41% | 34 | 23% | 34 | 23% | 0 | 0% | 82 | 55% |
| Physician Services | 41 | 11% | 14 | 34% | 10 | 24% | 1 | 2% | 16 | 39% |
| **Totals** | **368** | **100%** | **112** | **30%** | **113** | **31%** | **2** | **1%** | **141** | **38%** |

**HEAU Cases**
**Subject of Complaints**

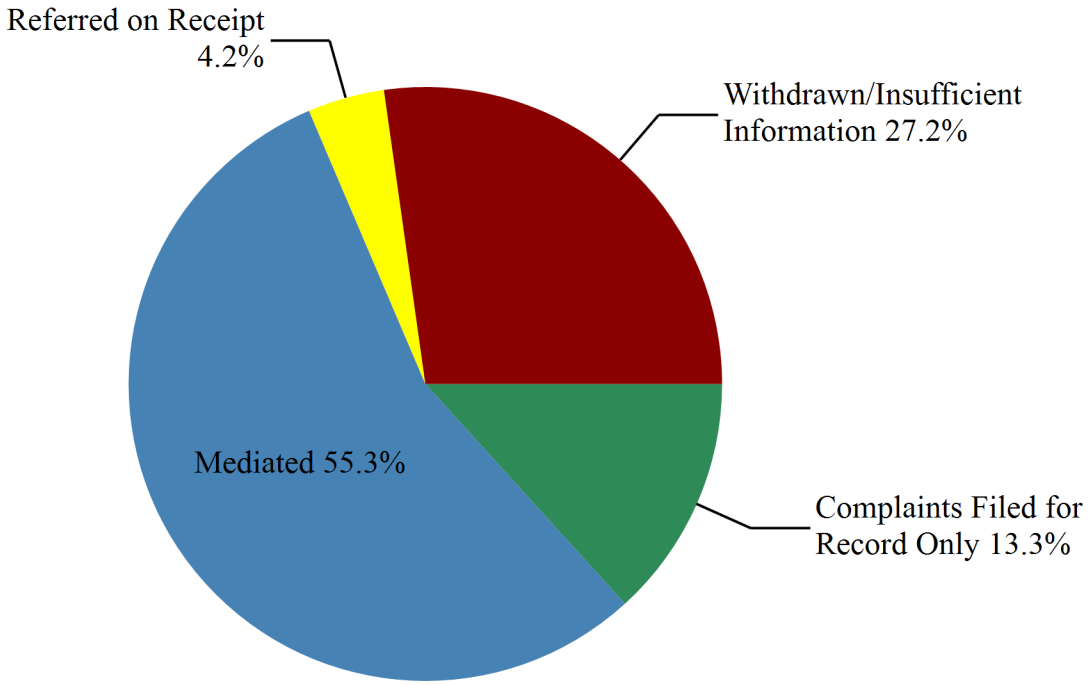
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, 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 2024. The HEAU closed 1,949 complaints. Some complaints were filed against more than one industry.




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

**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 694 Appeals and Grievances cases closed by the HEAU during FY 2024.



**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 2024. "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 384 cases in FY 2024. 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 | 4 | 0 | 0% | 4 | 100% |
| Not State Regulated | 21 | 10 | 48% | 11 | 52% |
| **Total Complaints** | **25** | **10** | **40%** | **15** | **60%** |
| **AIM Specialty Health** | | | | | |
| State Regulated | 2 | 2 | 100% | 0 | 0% |
| Not State Regulated | 2 | 2 | 100% | 0 | 0% |
| **Total Complaints** | **4** | **4** | **100%** | **0** | **0%** |
| **All Savers Insurance Co.** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Allied Benefit Systems, LLC** | | | | | |
| Not State Regulated | 1 | 0 | 0% | 1 | 100% |
| **Total Complaints** | **1** | **0** | **0%** | **1** | **100%** |
| **AmeriBen** | | | | | |
| Not State Regulated | 1 | 0 | 0% | 1 | 100% |
| **Total Complaints** | **1** | **0** | **0%** | **1** | **100%** |
| **Anthem Blue Cross and Blue Shield** | | | | | |
| Not State Regulated | 8 | 5 | 63% | 3 | 38% |
| **Total Complaints** | **8** | **5** | **63%** | **3** | **38%** |
| **Blue Cross Blue Shield of Massachusetts** | | | | | |
| Not State Regulated | 2 | 1 | 50% | 1 | 50% |
| **Total Complaints** | **2** | **1** | **50%** | **1** | **50%** |

| Carrier | Total Cases | Upheld | | Overturned/Modified | |
|---|---|---|---|---|---|
| **Blue Cross Blue Shield of Texas** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **BlueCross BlueShield of Illinois** | | | | | |
| Not State Regulated | 3 | 2 | 67% | 1 | 33% |
| **Total Complaints** | **3** | **2** | **67%** | **1** | **33%** |
| **CareFirst** | | | | | |
| State Regulated | 78 | 37 | 47% | 41 | 53% |
| Not State Regulated | 47 | 23 | 49% | 24 | 51% |
| **Total Complaints** | **125** | **60** | **48%** | **65** | **52%** |
| **CareFirst Administrators** | | | | | |
| Not State Regulated | 7 | 6 | 86% | 1 | 14% |
| **Total Complaints** | **7** | **6** | **86%** | **1** | **14%** |
| **CareFirst the Dental Network** | | | | | |
| State Regulated | 4 | 1 | 25% | 3 | 75% |
| **Total Complaints** | **4** | **1** | **25%** | **3** | **75%** |
| **CIGNA** | | | | | |
| State Regulated | 4 | 1 | 25% | 3 | 75% |
| Not State Regulated | 30 | 11 | 37% | 19 | 63% |
| **Total Complaints** | **34** | **12** | **35%** | **22** | **65%** |
| **Cigna Dental** | | | | | |
| Not State Regulated | 2 | 2 | 100% | 0 | 0% |
| **Total Complaints** | **2** | **2** | **100%** | **0** | **0%** |
| **Conifer Health Solutions** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Consolidated Commercial Services, LLC** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |

| Carrier | Total Cases | Upheld | | Overturned/Modified | |
|---|---|---|---|---|---|
| **CVS Caremark** | | | | | |
| State Regulated | 6 | 2 | 33% | 4 | 67% |
| Not State Regulated | 15 | 6 | 40% | 9 | 60% |
| **Total Complaints** | **21** | **8** | **38%** | **13** | **62%** |
| **Delta Dental** | | | | | |
| State Regulated | 4 | 1 | 25% | 3 | 75% |
| Not State Regulated | 4 | 3 | 75% | 1 | 25% |
| **Total Complaints** | **8** | **4** | **50%** | **4** | **50%** |
| **Dentegra Insurance Company** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Dominion National** | | | | | |
| State Regulated | 1 | 0 | 0% | 1 | 100% |
| Not State Regulated | 1 | 0 | 0% | 1 | 100% |
| **Total Complaints** | **2** | **0** | **0%** | **2** | **100%** |
| **EviCore Healthcare** | | | | | |
| State Regulated | 1 | 0 | 0% | 1 | 100% |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **2** | **1** | **50%** | **1** | **50%** |
| **Express Scripts** | | | | | |
| Not State Regulated | 3 | 2 | 67% | 1 | 33% |
| **Total Complaints** | **3** | **2** | **67%** | **1** | **33%** |
| **Freedom Life Insurance Company of America** | | | | | |
| State Regulated | 2 | 2 | 100% | 0 | 0% |
| **Total Complaints** | **2** | **2** | **100%** | **0** | **0%** |
| **Government Employees Health Association (GEHA)** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |

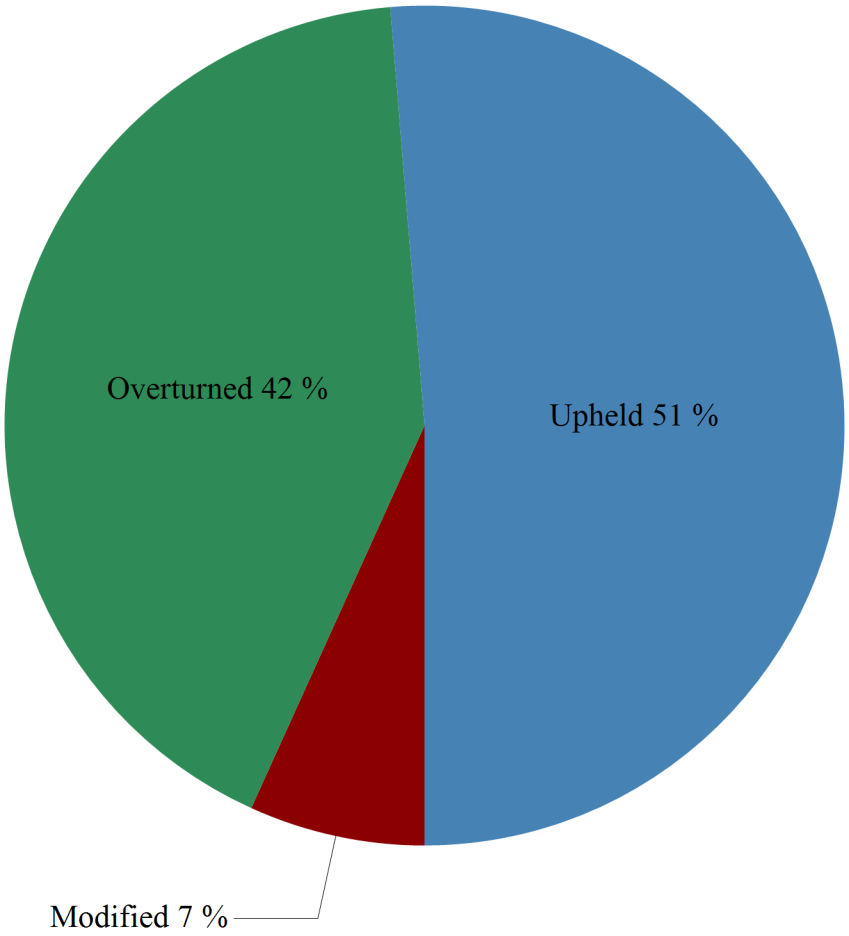
| Carrier | Total Cases | Upheld | | Overturned/Modified | |
|---|---|---|---|---|---|
| **Guardian Life Insurance Company of America** | | | | | |
| State Regulated | 4 | 1 | 25% | 3 | 75% |
| Not State Regulated | 2 | 1 | 50% | 1 | 50% |
| **Total Complaints** | **6** | **2** | **33%** | **4** | **67%** |
| **Highmark** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Horizon Blue Cross Blue Shield of New Jersey** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Humana** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Humana Dental, Inc.** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Humana Military/Tricare** | | | | | |
| Not State Regulated | 1 | 0 | 0% | 1 | 100% |
| **Total Complaints** | **1** | **0** | **0%** | **1** | **100%** |
| **Johns Hopkins Employer Health Programs** | | | | | |
| Not State Regulated | 2 | 0 | 0% | 2 | 100% |
| **Total Complaints** | **2** | **0** | **0%** | **2** | **100%** |
| **Kaiser Permanente Maryland Medicaid HealthChoice** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Kaiser Permanente of the Mid Atlantic States** | | | | | |
| State Regulated | 25 | 11 | 44% | 14 | 56% |
| Not State Regulated | 4 | 1 | 25% | 3 | 75% |
| **Total Complaints** | **29** | **12** | **41%** | **17** | **59%** |

| Carrier | Total Cases | Upheld | | Overturned/Modified | |
|---|---|---|---|---|---|
| **Liberty Dental Plan** | | | | | |
| State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **MedImpact Healthcare Systems** | | | | | |
| Not State Regulated | 1 | 0 | 0% | 1 | 100% |
| **Total Complaints** | **1** | **0** | **0%** | **1** | **100%** |
| **Metropolitan Life Insurance Company** | | | | | |
| State Regulated | 1 | 0 | 0% | 1 | 100% |
| Not State Regulated | 1 | 0 | 0% | 1 | 100% |
| **Total Complaints** | **2** | **0** | **0%** | **2** | **100%** |
| **Optum Rx** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **OptumHealth Care Solutions, LLC** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Principal Life Insurance Company** | | | | | |
| State Regulated | 2 | 2 | 100% | 0 | 0% |
| **Total Complaints** | **2** | **2** | **100%** | **0** | **0%** |
| **Quantum Health, Inc** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **SAMBA** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **Sisco** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |

| Carrier | Total Cases | Upheld | | Overturned/Modified | |
|---|---|---|---|---|---|
| **TurningPoint Healthcare Solutions, LLC** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **United Concordia Insurance Company** | | | | | |
| Not State Regulated | 6 | 6 | 100% | 0 | 0% |
| **Total Complaints** | **6** | **6** | **100%** | **0** | **0%** |
| **UnitedHealthcare** | | | | | |
| State Regulated | 32 | 15 | 47% | 17 | 53% |
| Not State Regulated | 58 | 35 | 60% | 23 | 40% |
| **Total Complaints** | **90** | **50** | **56%** | **40** | **44%** |
| **UPMC Health Plan** | | | | | |
| Not State Regulated | 1 | 1 | 100% | 0 | 0% |
| **Total Complaints** | **1** | **1** | **100%** | **0** | **0%** |
| **WEX Inc.** | | | | | |
| Not State Regulated | 1 | 0 | 0% | 1 | 100% |
| **Total Complaints** | **1** | **0** | **0%** | **1** | **100%** |

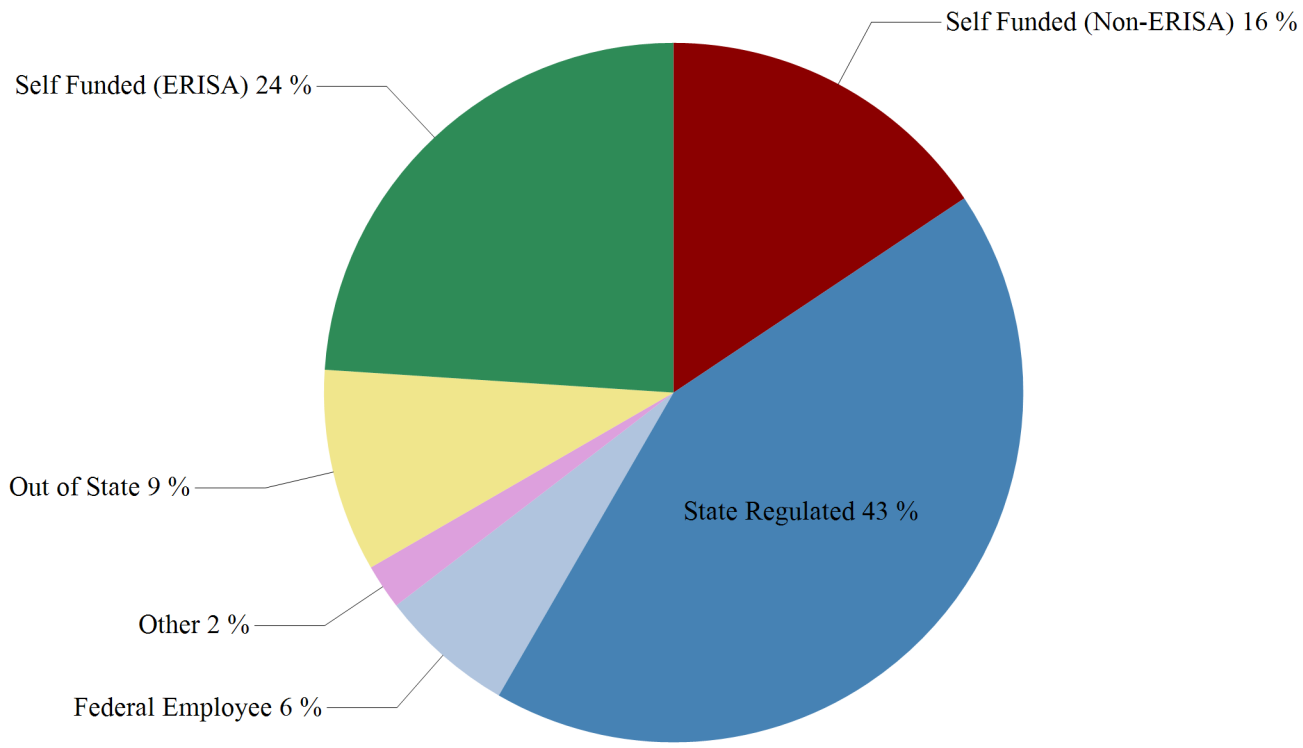
**HEAU Mediated Appeals and Grievances Cases**
**Disposition**

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 2024.



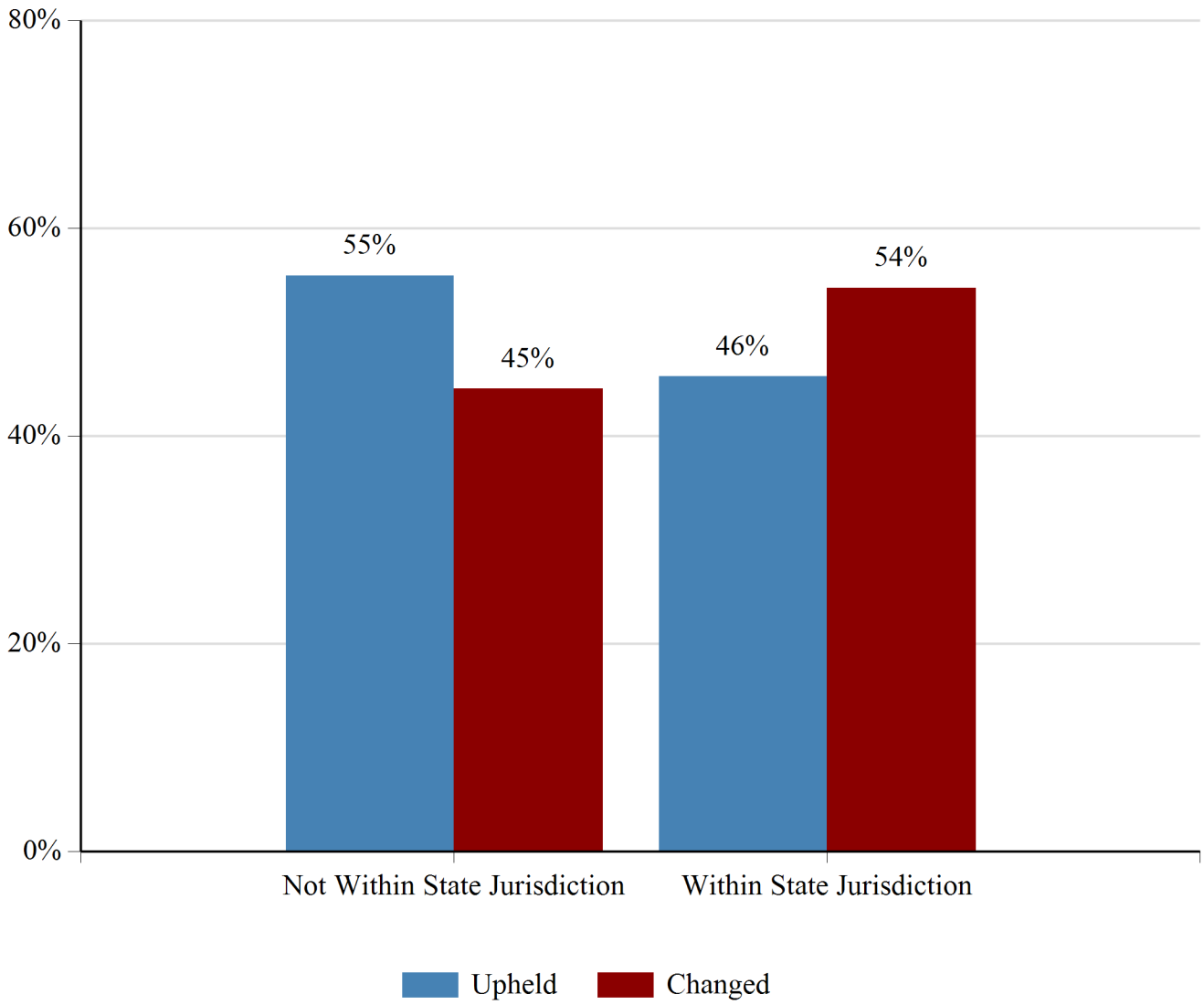
**HEAU Mediated Appeals and Grievances Cases**
**Types of Carriers**

The chart below identifies the primary carrier types involved in the 384 Appeals and Grievances cases the HEAU mediated and closed during FY 2024.



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

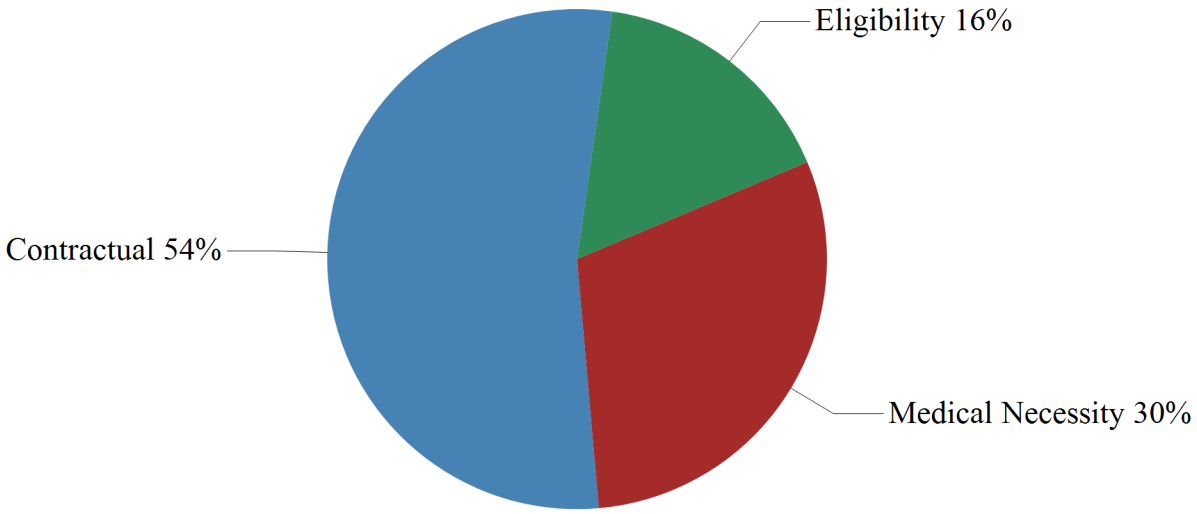
The chart below reflects the outcomes of the 384 Appeals and Grievances cases the HEAU mediated and closed during FY 2024 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



## HEAU Mediated Appeals and Grievances Cases

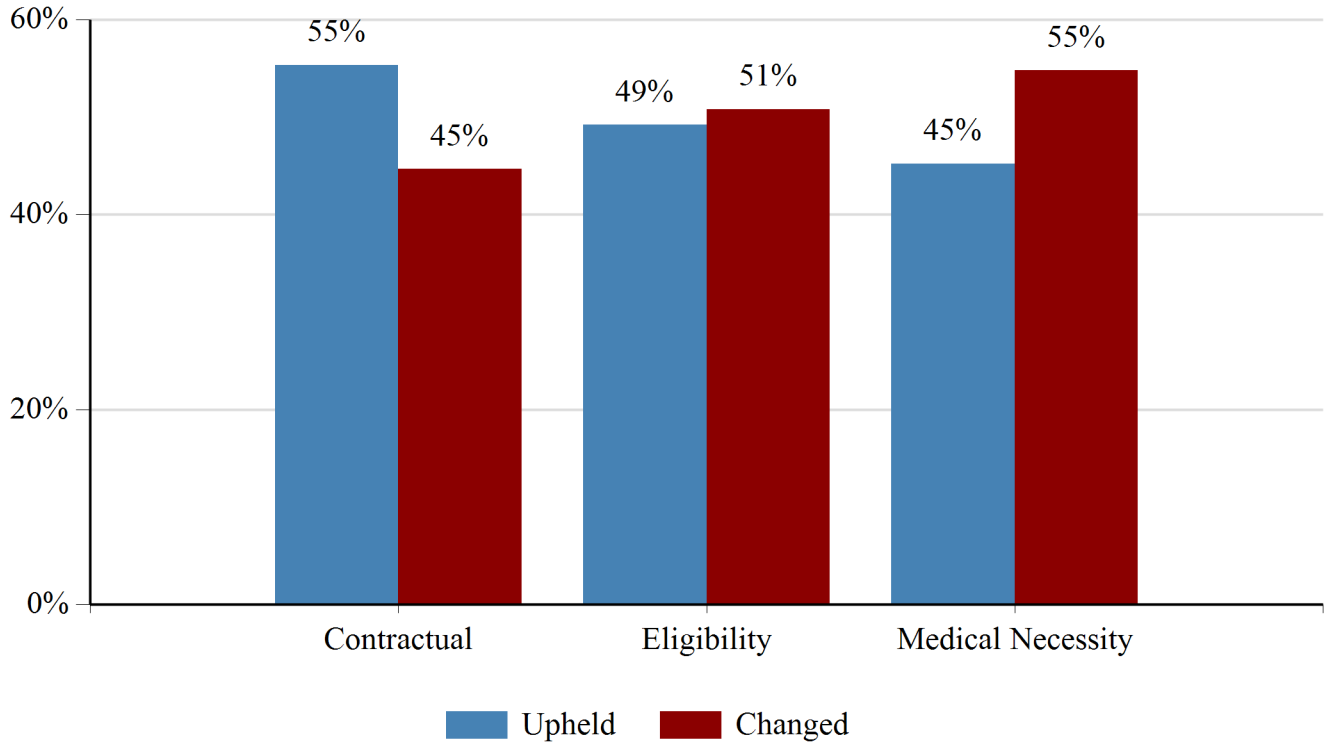
### Types of Denials

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 2024.




### Outcomes by Denial Type

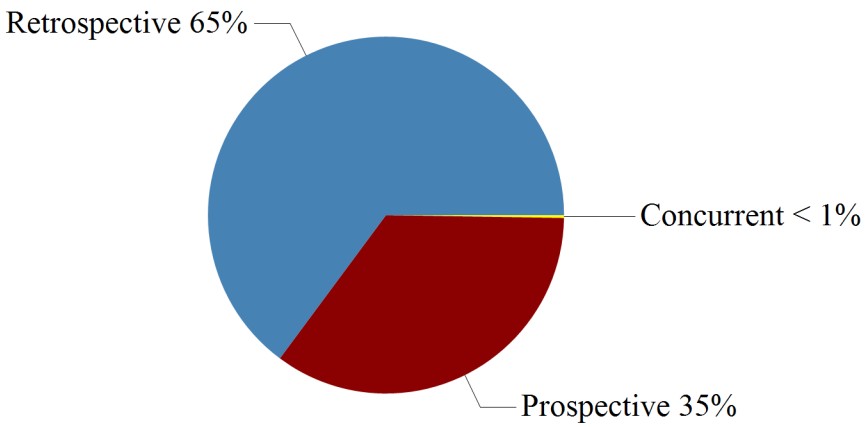
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2024.



## HEAU Mediated Appeals and Grievances Cases

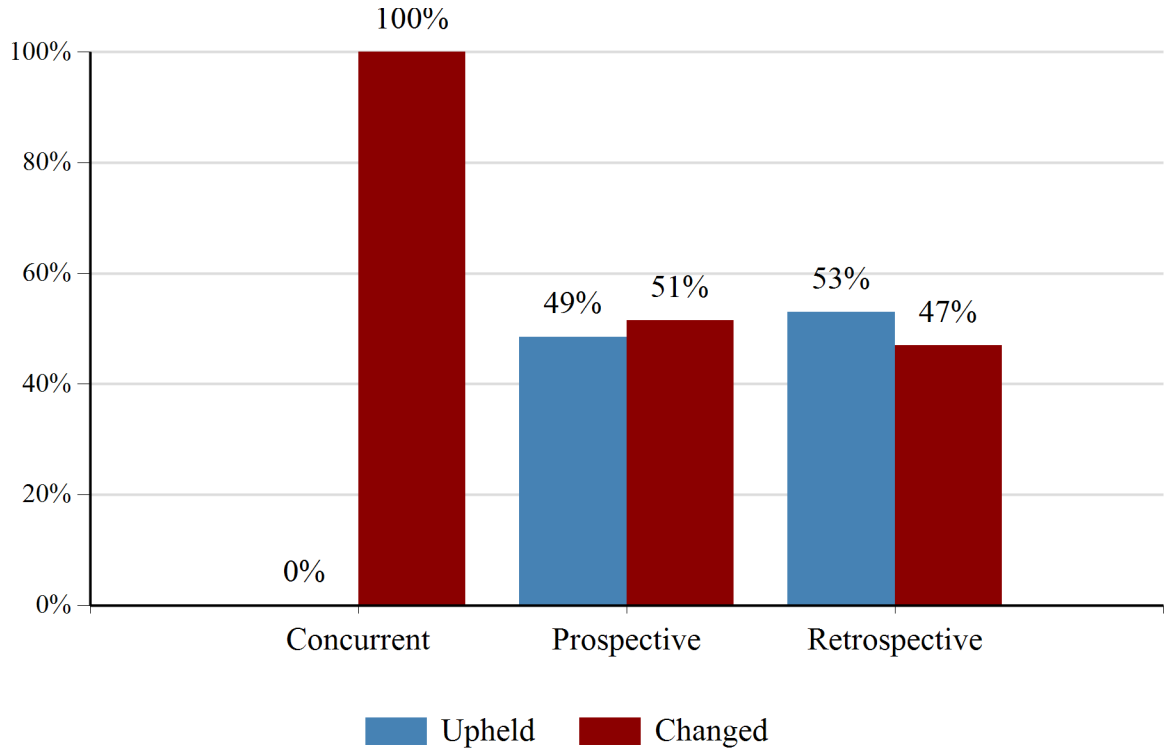
### Timing of Denials

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 2024. Eligibility disputes are treated as prospective denials.




### Outcomes by Timing of Denials

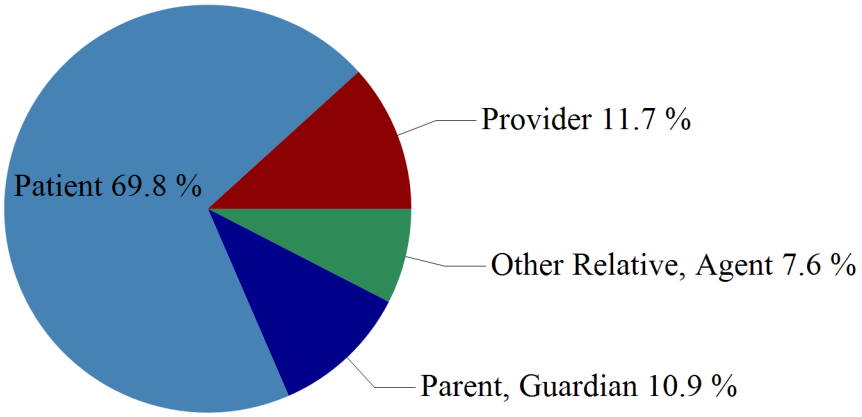
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2024 based on the timing of the decision.



## HEAU Mediated Appeals and Grievances Cases

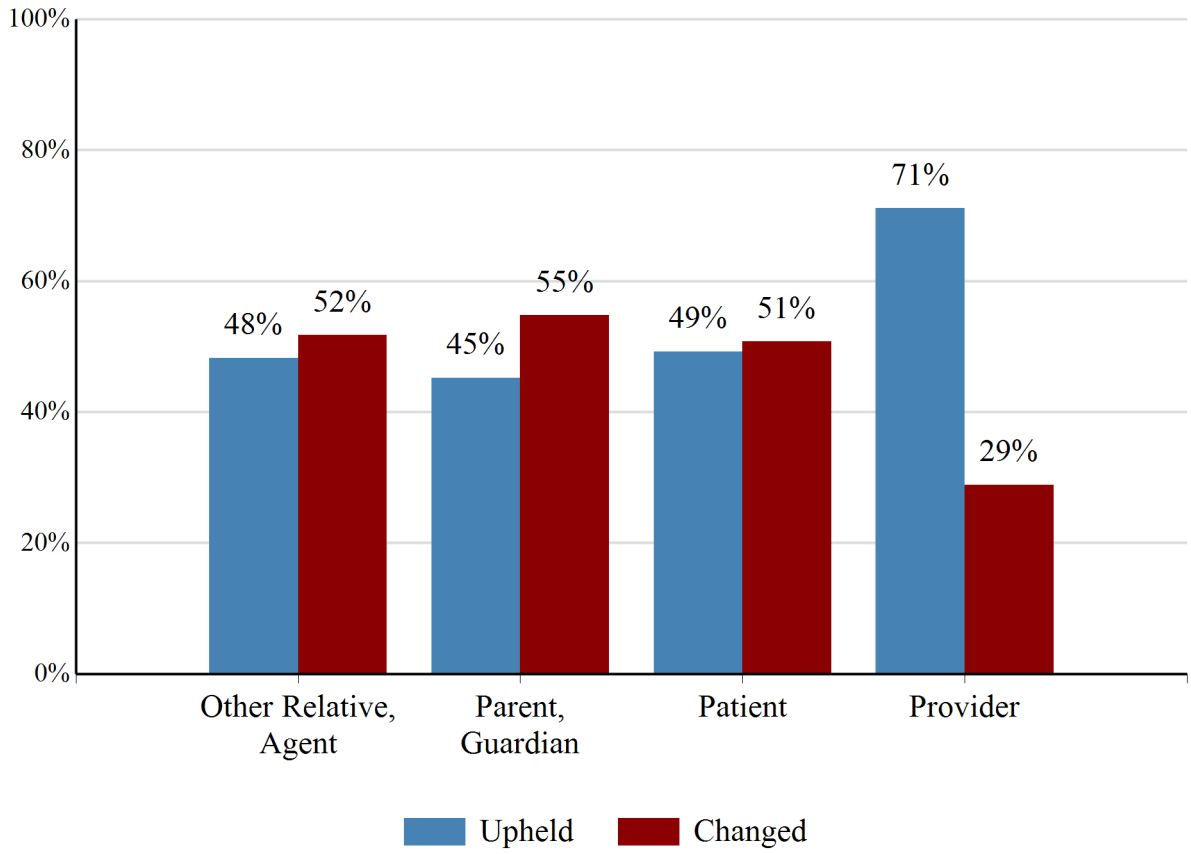
### Who Filed the Case

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 2024.



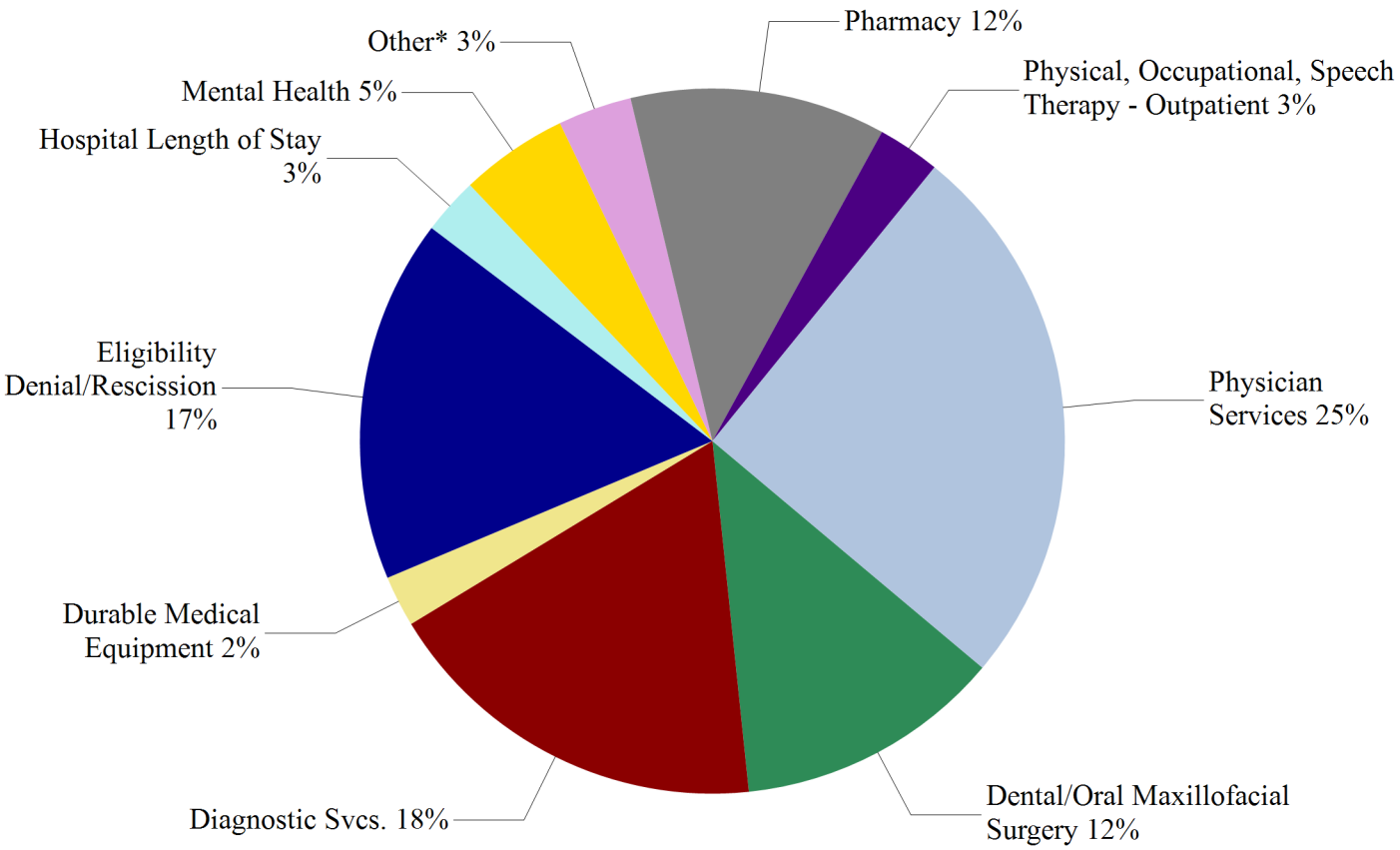

### Outcomes by Who Filed the Case

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 2024.



**HEAU Mediated Appeals and Grievances Cases**
**Types of Services Denied**

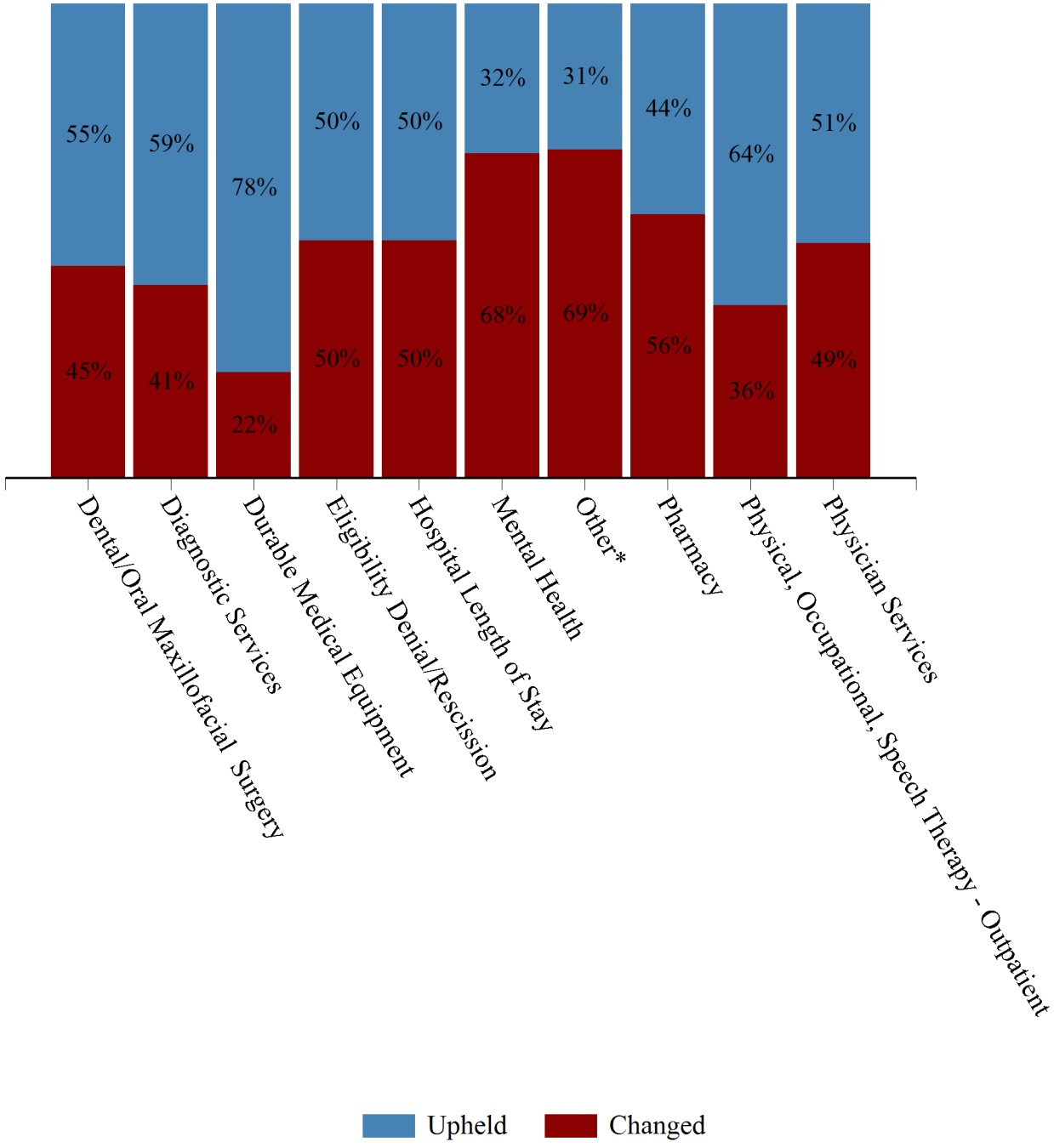
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2024.




* Other includes chiropractic, emergency room, optometry, skilled nursing facility and transport.

**HEAU Mediated Appeals and Grievances Cases**
**Outcomes by Service Type**

The chart below compares the outcomes of the Appeals and Grievances cases the HEAU mediated and closed during FY 2024 based on the types of services denied.




* Other includes chiropractic, emergency room, optometry, skilled nursing facility and transport.