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

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I. Executive Summary

The Health Education and Advocacy Unit (the "HEAU") of the Office of the Attorney General's Consumer Protection Division submits this annual report on the implementation of the Health Insurance Carrier Appeals and Grievances Law[1] (the "Appeals and Grievances Law") as required by the Maryland Insurance Article §15-10A-08 and the Maryland Commercial Law Article §13-4A-04. Section 15-10A-08(b)(1) of the Maryland Insurance Article requires the HEAU to annually publish 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 2017, beginning July 1, 2016 and concluding June 30, 2017.

This report (1) summarizes the Appeals and Grievances Law, (2) discusses how health insurance carriers, the MIA, and the HEAU implement the Appeals and Grievances Law, (3) summarizes grievances and complaints handled by carriers, the MIA and the HEAU, and (4) provides additional information about HEAU activities.

II. Overview of the Appeals and Grievances Process

State Law

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

In 2000, the General Assembly enacted Chapter 371[3] that expanded the grievances process to include the right to appeal contractual "coverage decisions." As a result, patients in Maryland who have coverage from a State-regulated plan can challenge any decision by a carrier that results in the total or partial denial of a covered health care service. In 2011, the General Assembly enacted Chapters 3 and 4,[4] which expanded the definition of "coverage decisions" to include a carrier's decision that someone is ineligible for coverage or a carrier's decision that results

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

[2] The Appeals and Grievances Law defines "carrier" as (1) an authorized issuer that provides health insurance in the State, (2) nonprofit health service plan, (3) health maintenance organization, (4) dental plan, or (5) any other person that offers a health benefit plan subject to regulation by the State.

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

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

in the rescission of an individual's coverage. As a result, since July 1, 2011, patients in Maryland have been able to challenge any decision by a carrier that results in the total or partial denial of a covered health care service, the denial of eligibility for coverage, or the rescission of coverage.

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

Federal Law

Under the Patient Protection and Affordable Care Act (the "ACA"), consumers have the right to appeal health plans' decisions rendered after March 23, 2010. Through guidance and regulations issued in July 2010[5] and July 2011[6], the U.S. Departments of Health and Human Services ("HHS"), Labor, and Treasury standardized internal claims and appeals and external review processes for group health insurance plans and health insurance issuers offering coverage in the group and individual markets. Under the regulations, consumers have the right to:

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

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

3. take their appeals to an independent third-party review organization ("IRO") for review of the insurer's decision (*external review*) for claims that involve (a) medical judgment (including but not limited to those based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer, or (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

In 2011, HHS deemed the Maryland laws dealing with internal and external review as meeting the "strict standards" included in the July 2010 rules. Accordingly, Maryland continues to implement the Appeals and Grievances Law as described below.

III. Phases of the Appeals and Grievances Process

For both adverse decisions and coverage decisions, the appeals and grievances process starts when a patient receives notice from the carrier that the carrier has rendered an adverse decision or coverage decision. Carriers must provide patients with a written notice that clearly states the basis of the carrier's adverse or coverage decision and that the HEAU is available to

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

mediate the dispute with the carrier or, if necessary, help the patient file a grievance or appeal. The notice must also inform the patient that an external review of the decision is available through the MIA or other external reviewer following exhaustion of the carrier's internal process. Patients may file a complaint with the MIA or other external reviewer prior to exhausting the internal grievance process only when there is a compelling reason.

After receiving the initial denial, the patient[7] may contest the determination through the carrier's internal grievance or appeal process. After receipt of the grievance or appeal, the carrier has 30 working days to review adverse decisions involving pending care and 45 working days for already-rendered care. For coverage decisions, the carrier has 60 working days after the date the appeal was filed with the carrier to render a decision. The carrier must issue a written decision to the patient at the conclusion of this internal process.

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

IV. Carrier Reporting

The Appeals and Grievances Law requires carriers to submit quarterly reports to the MIA on the number of adverse decisions issued and the number and outcomes of internal grievances the carriers handled. The MIA then forwards these reports to the HEAU for inclusion in this report. Although the carriers' quarterly report data provide some basic insight into the carriers' internal grievance processes, its usefulness is limited by several factors, including:

- The carriers are only required to report information on medical necessity denials (*adverse decisions*). Accordingly, the State does not collect comprehensive information about the types and outcomes of contractual exclusions of health care services (*coverage decisions*) rendered by the carriers.

- The carriers do not report data about each individual grievance. The carriers divide their data into medical service categories and report on the limited data within each category. As the categories are not standardized, reporting and categorizing may vary significantly from one carrier to another, making it difficult to compare one carrier's data to that of another.

- The diagnosis and procedure information carriers report is incomplete. Carriers must report diagnostic or treatment codes for a limited number of complaints. Although the limited data provide basic evaluative information, complete reporting would provide a more valuable tool in analyzing grievance data.

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

- Carriers are not required to identify the grievances that involved the MIA or the HEAU. As this information is not present, it is impossible to check the cases reported by carriers against the data recorded by the MIA or the HEAU to verify the consistency of data reporting.

- An analysis of the number of adverse decisions and grievances compared to enrollee numbers cannot be performed as carriers are not required to report membership or enrollee numbers.

Carrier Statistics FY 2017

In addition to the highlights below, charts providing statistical detail from the data submitted by the carriers appear on pages 13-21 of this report.

1. Carriers reported 67,100 adverse decisions in FY 2017, 12,378 more adverse decisions than reported in FY 2016. Six carriers reported increases in adverse decisions of greater than 100%. CareFirst BlueChoice, Inc. (4,529), Dental Benefit Providers of Illinois, Inc. (4,249), UnitedHealthcare Insurance Company (2,735), and Group Hospitalization and Medical Services, Inc. (2,216) reported the highest absolute increase in number of adverse decisions.

2. The carriers administratively reversed only 247 of the reported adverse decisions; less than 1%.

3. In FY 2017, consumers filed 6,012 grievances, a decrease from the 6,219 grievances filed in FY 2016.

4. The largest percentage of grievances filed were in the dental (30%), pharmacy (30%), lab/radiology (19%), and physician (11%) service categories.

5. Overall, during the internal grievance process, carriers altered their original adverse decisions in 54% of the grievances reported in FY 2017; overturning 46% of their adverse decisions and modifying 8%.

6. Adverse decisions involving mental health/substance abuse services continue to be overturned or modified less than 50% of the time. In FY 2017, carriers reported an overturned or modified rate of only 25% for mental health and substance abuse services. This continues years of low reversal rates: 19% in FY 2016, 42% in FY 2015, 31% in FY 2014, 27% in FY 2013 and 23% in FY 2012.

7. Adverse decisions involving pharmacy services are the most likely to be overturned as reflected in a five year review of data; 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.[8]

When the MIA receives a written complaint from a member, a member's authorized representative, a health care provider or facility, the MIA will review it to determine if the complaint raises issues subject to the Appeals and Grievances Law. If the Appeals and Grievances Law applies, the MIA confirms that the insurance carrier's internal grievance process has been fully exhausted because the law requires that process to be fully exhausted prior to the MIA's involvement in the matter, unless there is a compelling reason for the MIA to act prior to the exhaustion process. If the carrier's internal process has been exhausted or if there is a compelling reason to bypass the internal grievance process, within 5 working days of receipt of the complaint, the MIA will contact the carrier in writing requesting a written response to the complaint. Unless an extension request from the carrier is granted by the MIA, the carrier shall respond to the MIA within 7 working days of receipt of the complaint (with the exception of a complaint that involves an emergency issue that must be resolved within 24 hours of receipt of the complaint), and the carrier must respond to the MIA by providing medical and claims information (including the health benefit contract) pertinent to the complaint and either uphold, reverse, or modify its denial. When the MIA does not have jurisdiction over the complaint or the carrier's internal grievance process has not been exhausted, the MIA refers the complainant to the HEAU so that the member, the member's authorized representative, a health care provider or facility can be assisted through the carrier's internal grievance process or external review process as applicable.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then the MIA will prepare the case for review. As part of the preparation, the MIA will contact the complainant and the carrier in writing, giving them a deadline for submitting additional documentation to be considered in the review as applicable. Once the MIA receives the proper 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

[8] While the MIA only conducts the external review for individuals with insured health benefits and the Department of Budget and Management for the State of Maryland and Cecil County Public Schools, with the exception of grandfathered plans, the ACA mandates external review processes for all group health insurance plans and health insurance issuers offering coverage in the group and individual markets.

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 2017

MIA-provided data are reported on the charts and tables contained on pages 22-29 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 937 complaints in FY 2017. After reviewing these complaints, the MIA determined that 430 involved MIA-regulated adverse decisions.

2. The MIA referred 65 complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 365 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 247 cases (68%). Conversely, the MIA upheld 118 (32%) of the carrier decisions.

4. Similar to FY 2016, the largest percentages of grievances filed were in the pharmacy (33%), dental care (17%), experimental (12%), and physician services (13%) 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 provision 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 2017

The HEAU Appeals and Grievances data[9] are reported in the charts and tables contained on pages 30-47 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 2017.

The HEAU closed 2,487 cases in FY 2017.

1. 55% 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. 1,145 of the complaints closed by the HEAU were appeals and grievances related cases. Not all of the 1,145 appeals and grievances complaints filed with the HEAU were mediated. Some consumers, or other persons, file complaints but never complete an authorization to release medical records form, or 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 1,145 appeals and grievances cases the HEAU closed during FY 2017, 867 or 76% involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 867 cases involved more than one carrier.

4. Of the 867 appeals and grievances cases the HEAU mediated during FY 2017, 31% were adverse decision (*medical necessity*) cases, 58% were coverage decision (*contractual exclusion*) cases, and 11% were eligibility denials.

5. The HEAU mediation process resulted in carriers overturning or modifying 51% of the appeals and grievances cases. The carriers overturned or modified 51% of the medical necessity cases, 49% of the coverage decision cases, and 64% of the eligibility denial cases.

6. HEAU mediation efforts resulted in carriers changing their decisions 61% of the time in cases involving at least one MIA-regulated plan. For cases involving non-regulated plans, the HEAU efforts resulted in carriers changing their decisions 43% of the time.

7. In FY 2017, the HEAU assisted patients in recovering or saving nearly $3.7 million dollars, including over $3.1 million in appeals and grievances cases.

[9] Detailed data related to the outcomes of cases handled by the HEAU unrelated to the Appeals and Grievances Law are not contained in this report; some general complaint numbers and categories are reported for informational purposes.

VII. Successes and Areas of Concern

Maryland's Appeals and Grievances Law and the assistance provided by the HEAU continue to provide significant benefits to consumers. As the report reflects, 51% 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 day-to-day case work highlight the importance of the consumer assistance the HEAU provides:

1. The HEAU received an urgent telephone call from the mother of a student who was scheduled, during a school break, to have major oral surgery to help remedy a congenital anomaly and associated medical symptoms. On multiple occasions, their health plan refused to preauthorize coverage for the surgery claiming an exclusion for oral surgery unless the surgery was for a congenital defect. The patient's mother filed an appeal but the hospital was threatening to cancel the surgery unless the parents paid over $13,000 up-front, within 48-72 hours, and agreed to withdraw the appeal with the health plan. The parents did not want to cancel the carefully timed surgery to await an appeal outcome and they also did not want to pay $13,000 out-of-pocket, especially when they had no idea what their ultimate out-of-pocket costs would be. We were able to work with the health plan and obtain a favorable coverage decision within 24 hours so the student could have her surgery as planned.

2. The HEAU received a complaint from a consumer who, after receiving preauthorization for the surgery, had an AICD (defibrillator) placed. The consumer's health plan then denied coverage for the surgery. During investigation, the HEAU discovered that the provider sought the required authorization for the surgery, but the authorization was granted the day after the surgery was performed. The health plan continued to refuse coverage during the internal appeal process but agreed to cover the procedure during the external appeal process with the MIA, saving the consumer over $70,000.

The HEAU addressed many marketplace concerns, including, health insurance rate review, balance billing, mental health parity, network adequacy standards, medical records costs, HIPAA violations and rights for consumers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), consumer protections on the State's Health Information Exchange and State's Health Benefit Exchange, advanced directives, wellness program issues, the opioid crisis, etc., during FY 2017.

An example of one such concern involved Medicare Equitable Relief:

The HEAU received complaints from consumers who did not receive the information necessary to make a properly informed decision regarding Medicare Part B enrollment at the time they became eligible for Medicare or during their marketplace enrollment periods. As a result, they mistakenly thought enrollment in qualified health plans through Maryland Health Connection

meant they did not need to enroll in Medicare. Those uninformed decisions left affected consumers facing a lifetime of enrollment penalties for late Medicare enrollment.

Recognizing the previous lack of clear notification in this complex area, Medicare officials offered time-limited equitable relief to eligible consumers allowing them, through September 30, 2017, to 1) enroll in Medicare Part B without penalty or 2) eliminate or reduce their Part B late enrollment penalty if they delayed enrollment when they had a qualified health plan.

The HEAU offered assistance to consumers in obtaining equitable relief and asked Maryland Health Connection to identify impacted individuals and notify them about the time-limited equitable relief. We worked closely with Maryland Health Connection and the Department of Aging to get the word out to impacted consumers.

In addition to our work aimed at mitigating the negative effects of a possible repeal of the ACA or weakening of health plan coverage, the HEAU is focused on several other Areas of Concern:

A. Outpatient Facility Fees

As reported in FY 2016, the HEAU continued to receive complaints in FY 2017 from consumers about surprise or excessive charges for outpatient facility fees by medical practices that have been acquired by hospital systems. Lack of notice about the outpatient facility fee is a chronic complaint; consumers say they would not have made or kept their appointment if they had been told about the fee beforehand. Consumers complain they are receiving the same services after acquisition as they received before acquisition, but are being charged a facility fee that provides them no value. A few examples highlight the problem:

1. A neurologist billed a consumer $119.52 for an office visit involving no special tests. She was also billed $1,465.82 by the hospital where the neurologist's practice was located. Both charges were within her $3,500.00 deductible. The consumer contended she was provided no oral or written notice that she would be charged an outpatient facility fee, or given any estimate of the fee, in advance. She would not have made or kept the appointment with this neurologist had she known. The surgeon who referred her was within the same hospital system, but she has not been charged outpatient facility fees in connection with his services. No relief has been offered to the consumer, despite her repeated requests. No response has been given by the hospital to the HEAU's detailed request for information regarding the consumer's complaint; the hospital has advised that a response is forthcoming.

2. A consumer was referred by a community physician for a sleep study consultation with a sleep medicine specialist at a local hospital with which the community physician was associated. The consumer was charged (within his deductible) a $143.71 facility fee and a $188.96 professional fee for his sleep study. He complains that "[a]t no point did either institution…inform me or give me an estimate of what the services will cost" and that the institution "should be up front with their costs first so that the consumer can make their choices fairly. Waiting until after takes the choice away from the consumer." No

response has been given by the institution to the HEAU's detailed request for information regarding the consumer's complaint.

Similar requests seeking detailed information about notice provided to consumers about these fees have been sent to several other hospitals.

The HEAU agrees with consumers who complain about these outpatient facility fees. Consumers should be told the costs, or range of possible costs, when making appointments so they can make informed decisions about where to obtain needed services. We will continue to gather information from hospital systems to determine whether a legislative or other solution is necessary to address this growing problem.

B. Prescription Drug Pricing

Numerous complaints were made in FY 2017 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, 9% were pharmacy-related; 33% 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. Throughout FY 2017, the HEAU continued to monitor pharmacy-related complaints for drug pricing and coverage issues that may merit future legislative action, including complaints about pharmacists being contractually prohibited from telling consumers if there is an option for them to pay less for their medically necessary prescriptions than their copay amount.

C. Genetic Privacy

In FY 2017, the U.S. Food and Drug Administration permitted 23andMe to market its Personal Genome Service Genetic Health Risk (GHR) tests for 10 diseases or conditions. The HEAU began its evaluation of the implications of that decision for Maryland consumers in FY 2017, and is continuing to explore ways to expand consumer protections against potential misuse of genetic information obtained by commercial companies that may or may not comply with HIPAA, Clinical Laboratory Improvement Amendments (CLIA) and other protective regulatory schemes. There is a concerning lack of transparency and accountability in the burgeoning genetic information industry. Legislative protections may be warranted because of the increasing commercial value of reselling genetic information, e.g., 23andMe has reportedly raised $491 million dollars in venture capital based on the company's current and potential contracts with pharmaceutical companies and others for access to its genetic information database.

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

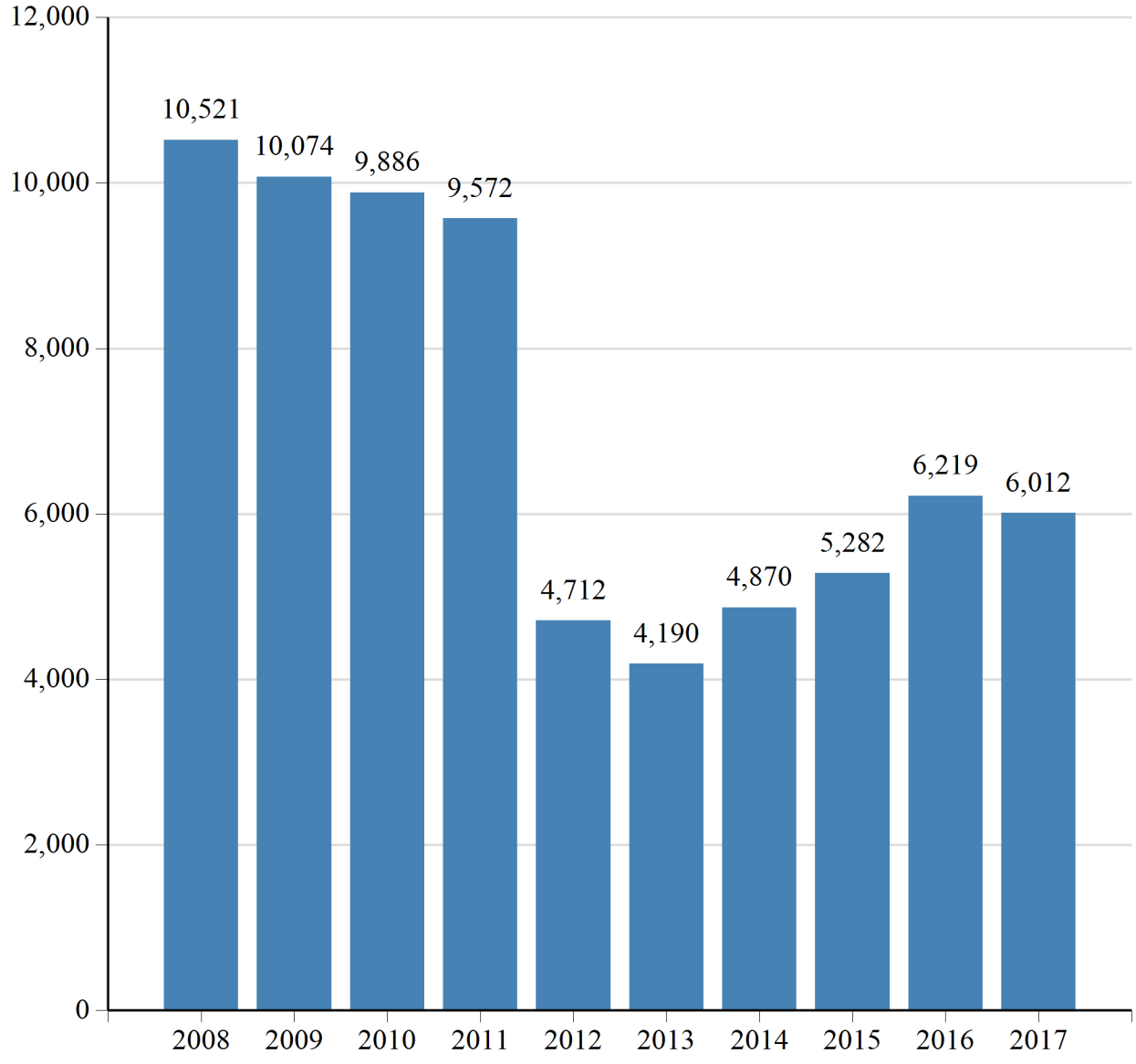
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
4 Ever Life Insurance Company	1	0	0	0%	0%
Aetna Dental Inc.	1,039	0	0	0%	0%
Aetna Health Inc. (a Pennsylvania corporation)	299	24	216	66%	34%
Aetna Life Insurance Company	290	21	180	53%	47%
All Savers Insurance Company	200	0	12	42%	58%
Alpha Dental Programs, Inc.	0	0	4	0%	100%
Ameritas Life Insurance Corp.	233	0	31	45%	55%
CareFirst BlueChoice, Inc.	13,501	0	1,298	52%	48%
Carefirst of Maryland, Inc.	8,024	0	407	43%	57%
CIGNA Dental Health of Maryland, Inc.	58	0	0	0%	0%
CIGNA Health and Life Insurance Company	5,892	125	434	58%	42%
Companion Life Insurance Company	2	0	2	0%	100%
Connecticut General Life Insurance Company	16	0	0	0%	0%
Coventry Health and Life Insurance Company	13	0	2	50%	50%
Delta Dental Insurance Company	8	0	3	100%	0%
Delta Dental of Pennsylvania	82	0	2	100%	0%
Dental Benefit Providers of Illinois, Inc.	4,759	0	454	25%	75%
Dentegra Insurance Company	1	0	0	0%	0%
Dominion Dental Services, Inc.	431	0	46	26%	74%
Evergreen Health Cooperative Inc.	873	0	70	31%	69%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Evergreen Health, Inc.	1,010	8	97	26%	74%
Golden Rule Insurance Company	22	0	7	57%	43%
Group Dental Service of Maryland, Inc.	4,840	0	5	60%	40%
Group Hospitalization and Medical Services, Inc.	9,823	0	602	48%	52%
Guarantee Trust Life Insurance Company	0	0	1	100%	0%
Guardian Life Insurance Company of America	981	0	383	26%	74%
Humana Insurance Company	1	1	0	0%	0%
HumanaDental Insurance Company	135	0	4	75%	25%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	594	6	18	78%	22%
Kaiser Permanente Insurance Company	35	0	11	64%	36%
Lincoln Life & Annuity Company of New York	2	0	0	0%	0%
Lincoln National Life Insurance Company	120	26	0	0%	0%
MAMSI Life and Health Insurance Company	789	0	111	44%	56%
Metropolitan Life Insurance Company	290	24	15	87%	13%
National Health Insurance Company	30	0	0	0%	0%
Optimum Choice, Inc.	1,875	0	173	39%	61%
Principal Life Insurance Company	178	0	37	68%	32%
Reliance Standard Life Insurance Company	29	0	4	50%	50%
Standard Insurance Company	19	0	2	50%	50%
Standard Security Life Insurance Company of New York	0	0	32	78%	22%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Starmount Life Insurance Company	1	1	0	0%	0%
Sun Life Assurance Company of Canada	69	0	29	41%	59%
Union Security Insurance Company	574	0	11	27%	73%
United Concordia Dental Plans, Inc.	4	0	3	100%	0%
United Concordia Insurance Company	2	0	1	100%	0%
United Concordia Life and Health Insurance Company	1,170	0	260	54%	46%
United States Life Insurance Company In the City of New York	1	0	1	0%	100%
UnitedHealthcare Insurance Company	8,171	11	953	45%	55%
UnitedHealthcare of the Mid-Atlantic, Inc.	613	0	91	46%	54%
Totals	**67,100**	**247**	**6,012**	**46%**	**54%**

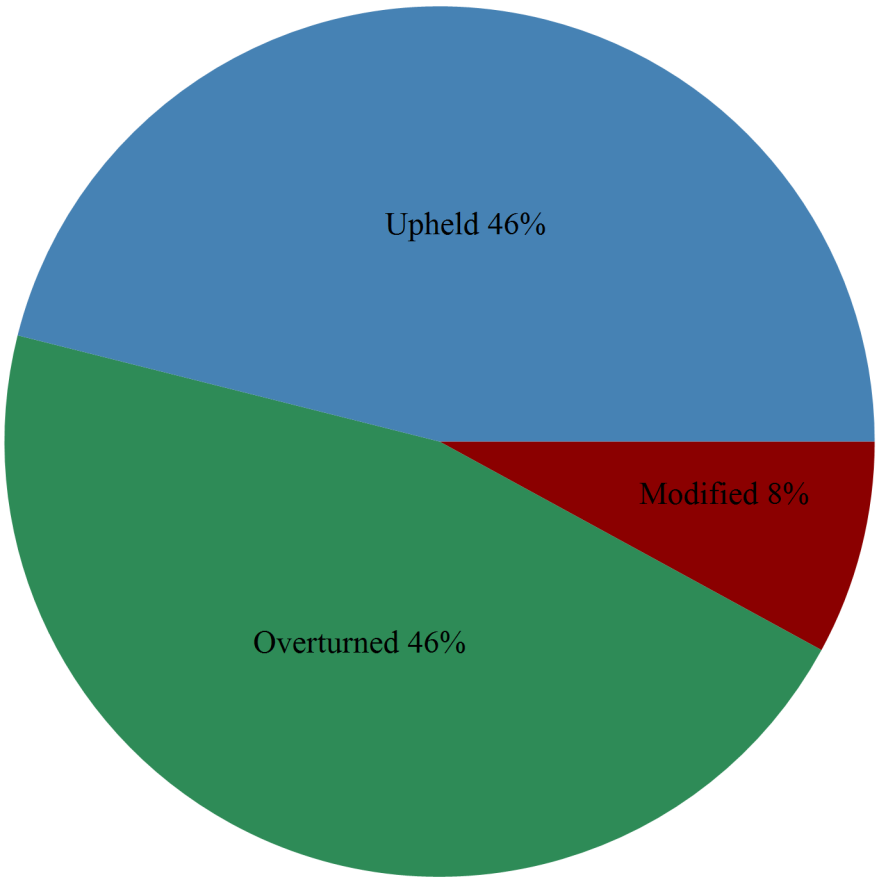
Carrier Grievances Cases
Number of Grievances Since Fiscal Year 2008

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.



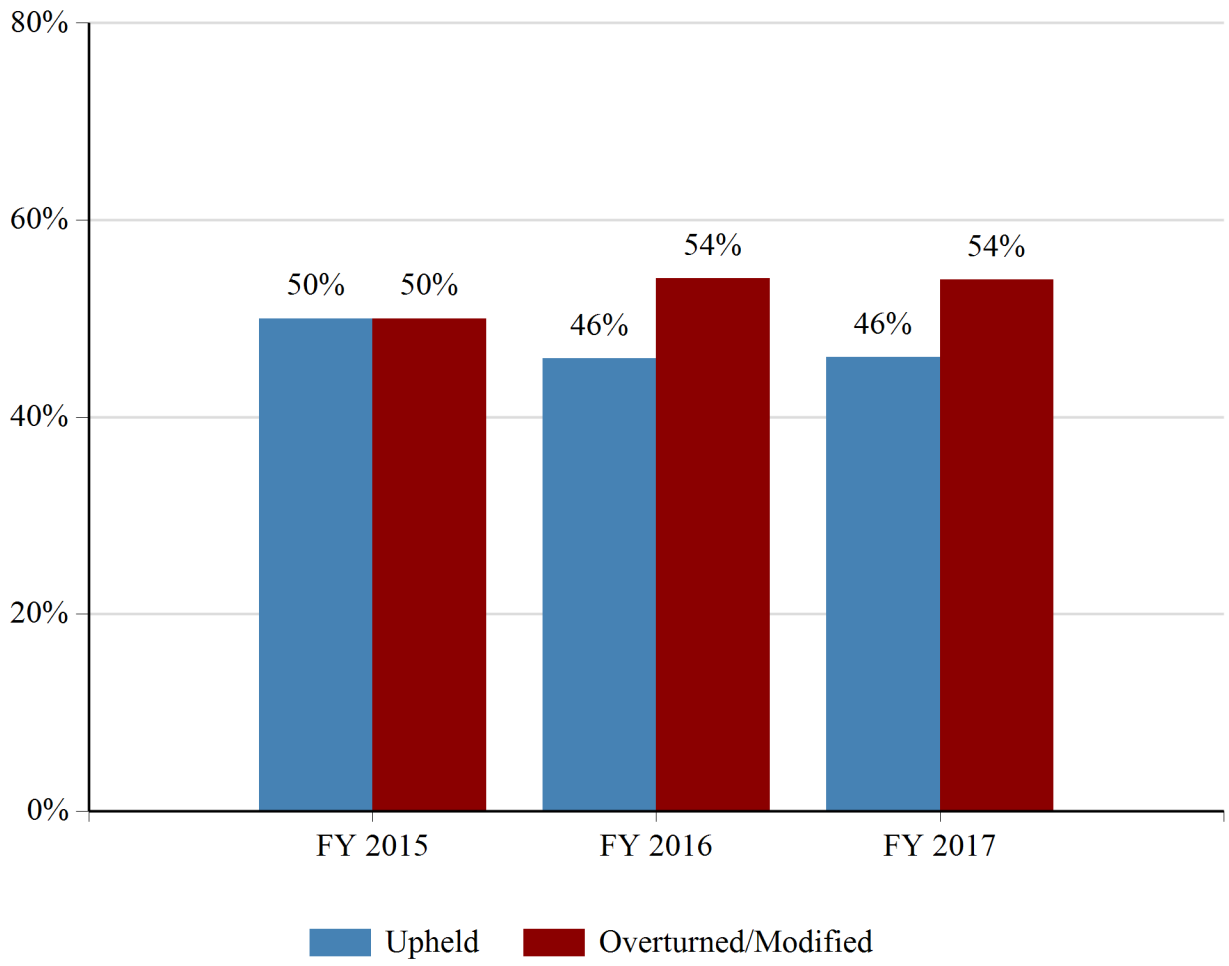
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 6,012 internal grievances filed with carriers in FY 2017, 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 2017, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	24,822	36.993%	1,781	29.624%
Durable Medical Equipment	1,569	2.338%	134	2.229%
Emergency Room	109	0.162%	10	0.166%
Home Health	257	0.383%	7	0.116%
Inpatient Hospital	1,284	1.914%	131	2.179%
Laboratory, Radiology	12,821	19.107%	1,147	19.079%
Mental Health / Substance Abuse	1,436	2.140%	141	2.345%
Other*	550	0.820%	116	1.929%
Pharmacy	17,239	25.692%	1,797	29.890%
Physician	6,344	9.455%	662	11.011%
PT, OT, ST, including inpatient rehabilitation	631	0.940%	71	1.181%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	38	0.057%	15	0.250%
Totals	**67,100**	**100%**	**6,012**	**100%**

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

Carrier Grievances Cases
Outcomes by Service Type

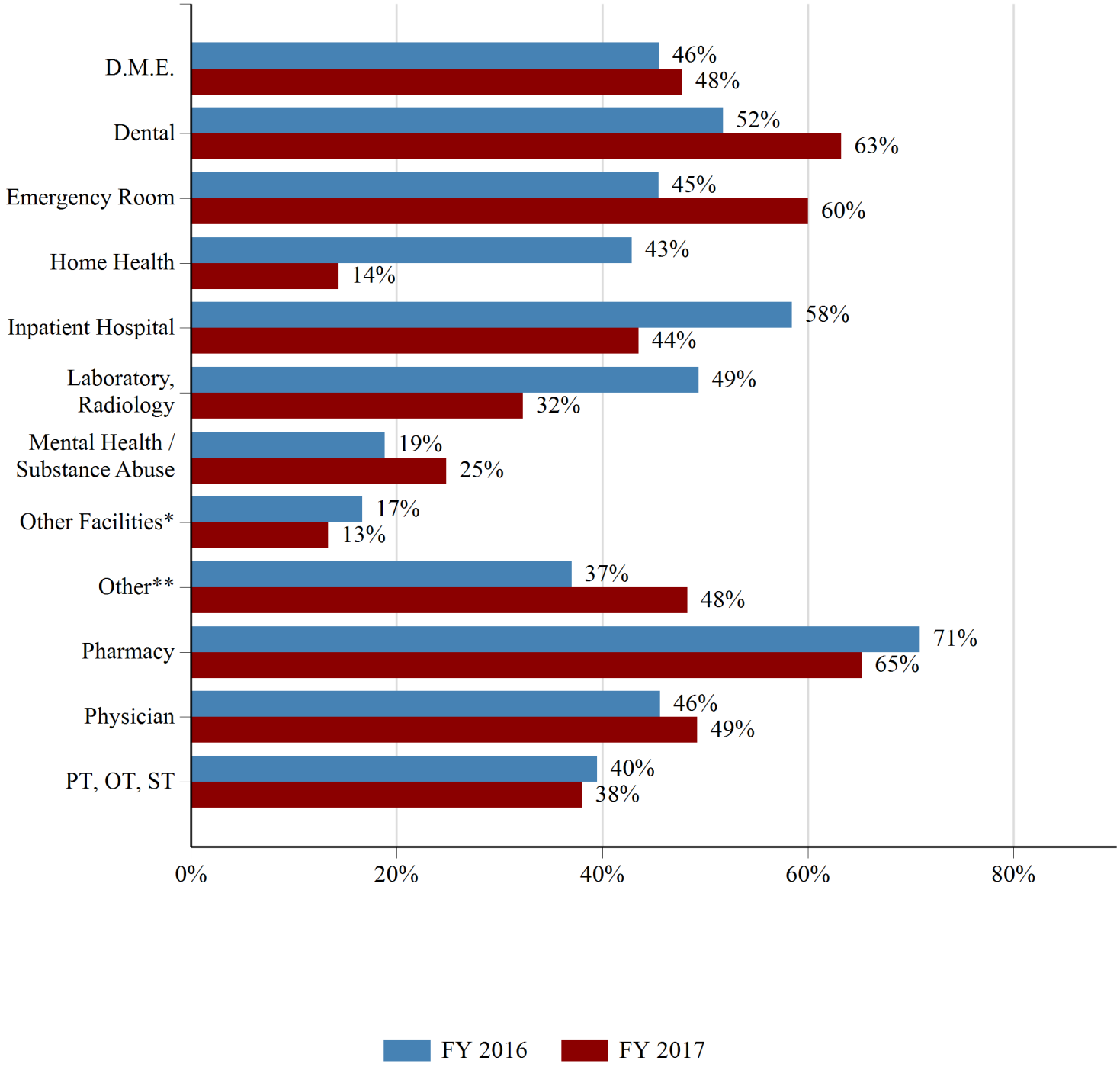
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Dental	1,781	37%	63%
Durable Medical Equipment	134	52%	48%
Emergency Room	10	40%	60%
Home Health	7	86%	14%
Inpatient Hospital	131	56%	44%
Laboratory, Radiology	1,147	68%	32%
Mental Health / Substance Abuse	141	75%	25%
Other*	116	52%	48%
Pharmacy	1,797	35%	65%
Physician	662	51%	49%
PT, OT, ST, including inpatient rehabilitation	71	62%	38%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	15	87%	13%
Totals	**6,012**	**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 2016 and FY 2017.

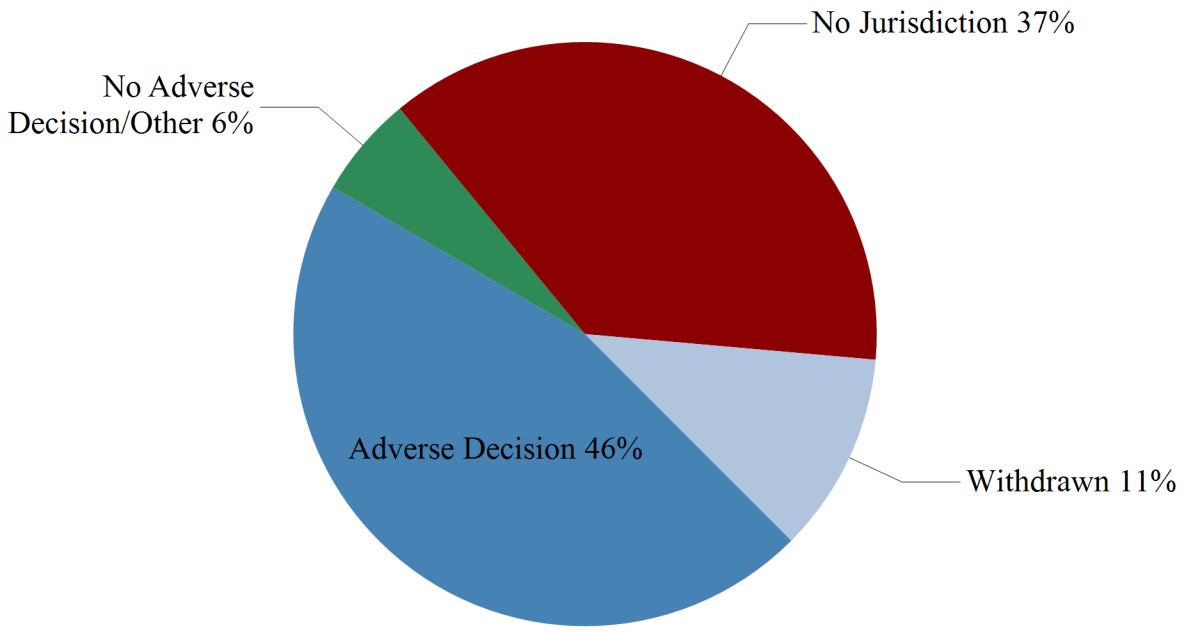


* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.
** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints
Initial Review of Cases

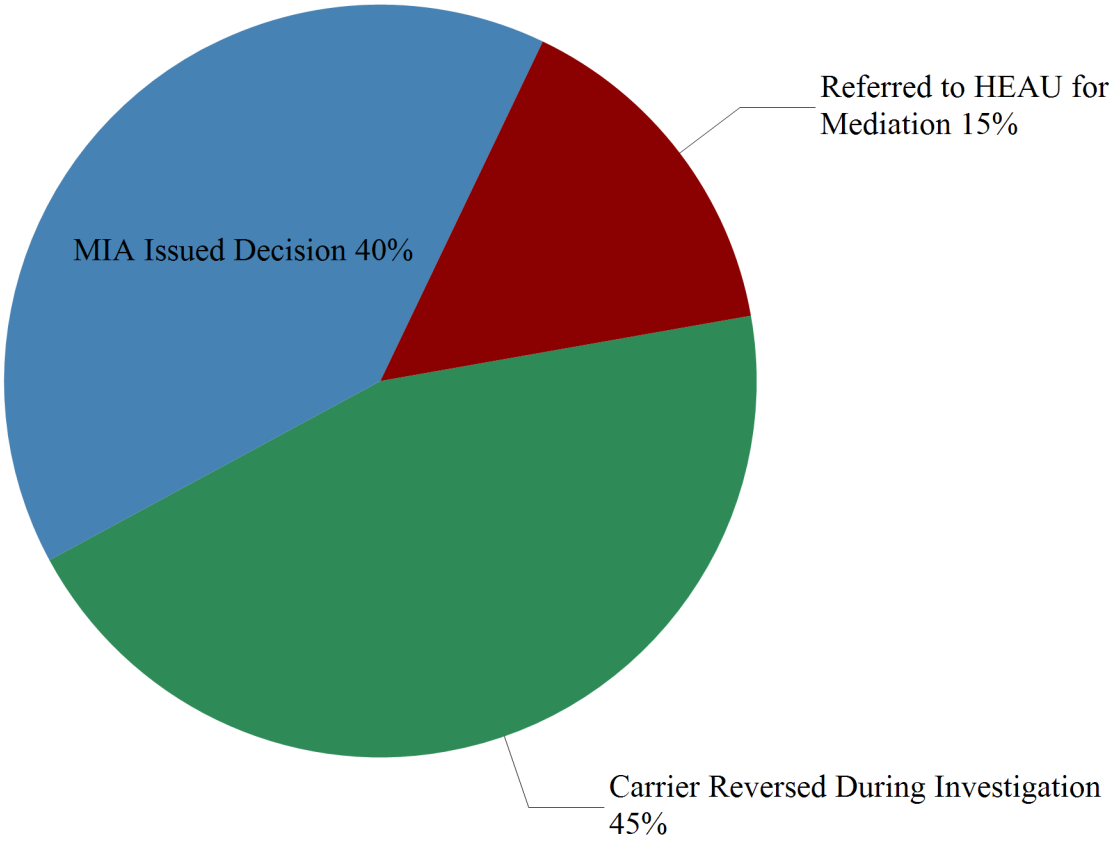
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some 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 937 cases filed with the MIA's Appeals and Grievances Unit during FY 2017.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2017, the MIA determined that 430 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 65 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 430 grievances the MIA reviewed during FY 2017.



MIA Appeals and Grievances Cases
Carriers and Disposition

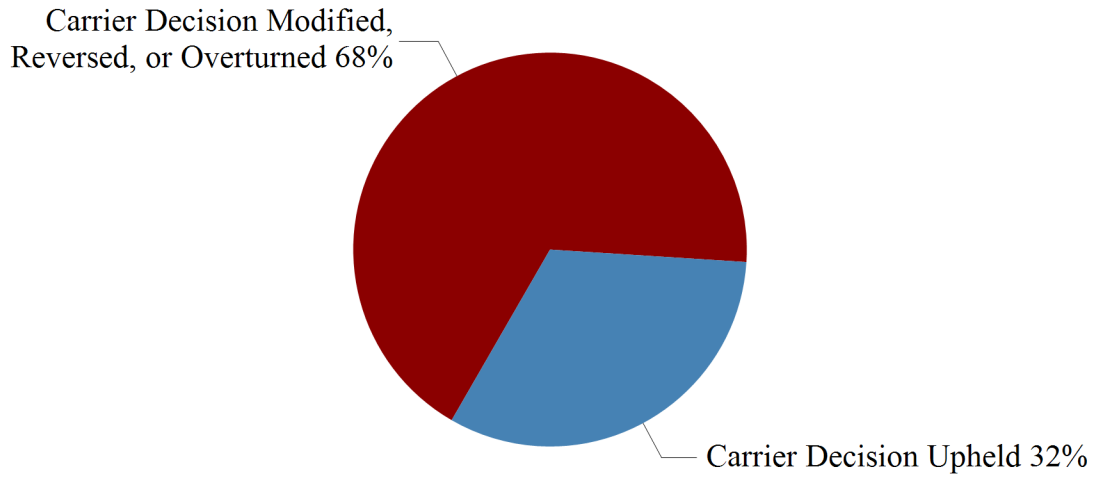
The table below details the outcomes of the 365 grievances complaints the MIA investigated during FY 2017. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	7	2	28.6%	3	42.9%	0	0.0%	2	28.6%
Aetna Life Insurance Company	9	2	22.2%	1	11.1%	0	0.0%	6	66.7%
All Savers Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
CareFirst BlueChoice, Inc.	84	43	51.2%	11	13.1%	0	0.0%	30	35.7%
Carefirst of Maryland, Inc.	54	21	38.9%	13	24.1%	1	1.9%	19	35.2%
CIGNA Health and Life Insurance Company	13	6	46.2%	0	0.0%	0	0.0%	7	53.8%
Coventry Health Care of Delaware, Inc.	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Delta Dental of Pennsylvania	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
Dominion Dental Services, Inc.	3	0	0.0%	0	0.0%	0	0.0%	3	100.0%
Evergreen Health Cooperative Inc.	11	0	0.0%	0	0.0%	0	0.0%	11	100.0%
Evergreen Health, Inc.	5	0	0.0%	0	0.0%	0	0.0%	5	100.0%
Express Scripts, Inc.	11	1	9.1%	0	0.0%	0	0.0%	10	90.9%
Group Dental Service of Maryland, Inc.	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Group Hospitalization and Medical Services, Inc.	19	8	42.1%	4	21.1%	0	0.0%	7	36.8%
Guardian Life Insurance Company of America	11	3	27.3%	1	9.1%	1	9.1%	6	54.5%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	9	4	44.4%	0	0.0%	0	0.0%	5	55.6%

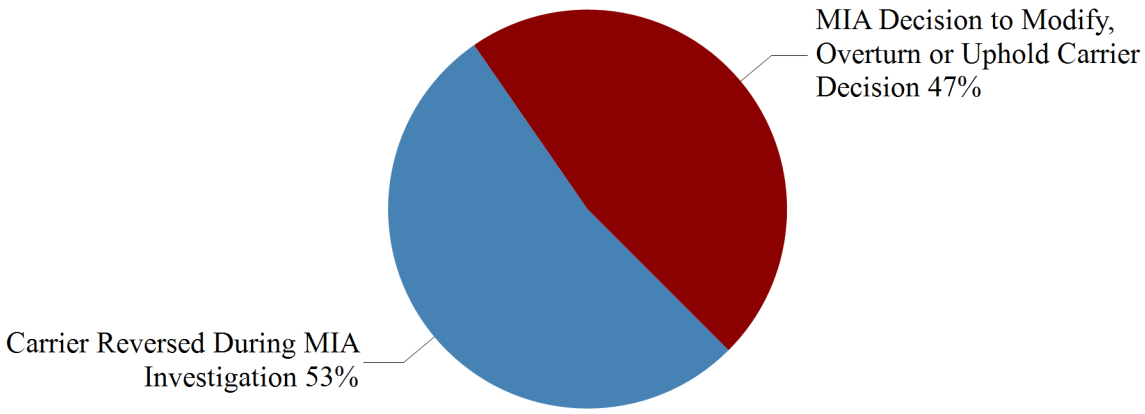
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
MAMSI Life and Health Insurance Company	8	2	25.0%	1	12.5%	1	12.5%	4	50.0%
National Health Insurance Company	1	0	0.0%	0	0.0%	1	100.0%	0	0.0%
Optimum Choice, Inc.	11	3	27.3%	1	9.1%	0	0.0%	7	63.6%
Principal Life Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
United Concordia Life and Health Insurance Company	7	2	28.6%	3	42.9%	0	0.0%	2	28.6%
UnitedHealthcare Insurance Company	70	14	20.0%	5	7.1%	3	4.3%	48	68.6%
UnitedHealthcare Life Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
UnitedHealthcare of the Mid-Atlantic, Inc.	12	3	25.0%	0	0.0%	1	8.3%	8	66.7%
UnitedHealthcare Services, Inc.	13	2	15.4%	3	23.1%	0	0.0%	8	61.5%
Totals	**365**	**118**	**32%**	**46**	**13%**	**8**	**2%**	**193**	**53%**

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 365 grievances the MIA investigated during FY 2017.

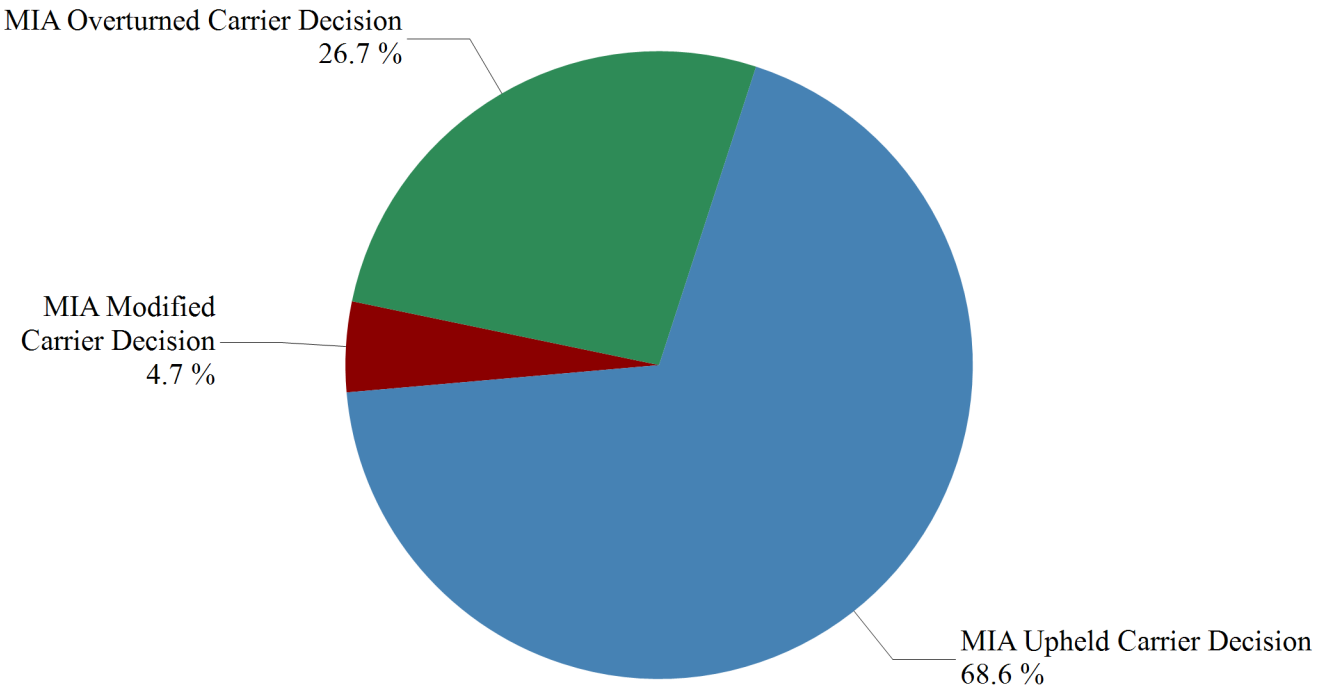


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 172 cases the MIA forwarded to an IRO for review in FY 2017.



MIA Appeals and Grievances Cases
Types of Services Denied and Outcomes

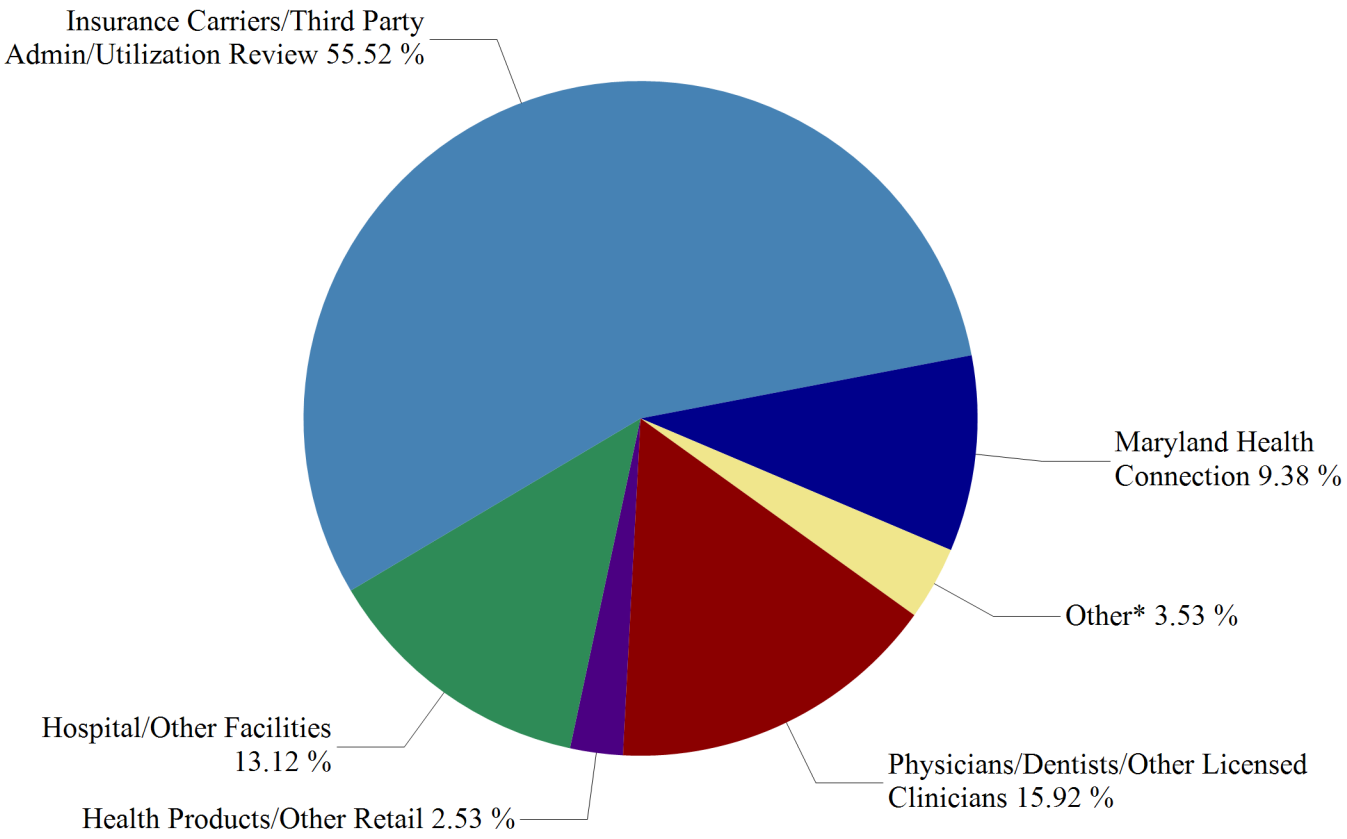
The table below identifies the types of services involved in grievances the MIA investigated during FY 2017. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Cosmetic	1	0%	0	0%	1	100%	0	0%	0	0%
Denial of Hospital Days	9	2%	4	44%	1	11%	0	0%	4	44%
Dental Care Services	62	17%	18	29%	10	16%	2	3%	32	52%
Durable Medical Equipment	14	4%	3	21%	1	7%	0	0%	10	71%
Emergency Room Denial	1	0%	0	0%	0	0%	0	0%	1	100%
Emergency Treatment Denial	1	0%	0	0%	0	0%	0	0%	1	100%
Experimental	43	12%	25	58%	14	33%	0	0%	4	9%
Eye Care Services	1	0%	1	100%	0	0%	0	0%	0	0%
Harvoni	1	0%	0	0%	0	0%	0	0%	1	100%
In-Patient Rehabilitation Services	1	0%	1	100%	0	0%	0	0%	0	0%
Lab, Imaging, Test Services	26	7%	11	42%	3	12%	1	4%	11	42%
Laboratory Services	2	1%	1	50%	0	0%	0	0%	1	50%
Lymphedema Treatment	2	1%	0	0%	1	50%	0	0%	1	50%
Medical Food	1	0%	0	0%	0	0%	0	0%	1	100%
Mental Health Partial Hospitalization	3	1%	1	33%	0	0%	0	0%	2	67%
Mental Health/Substance Abuse (Inpatient) Services	9	2%	6	67%	0	0%	1	11%	2	22%
Mental Health/Substance Abuse (Outpatient) Services	3	1%	1	33%	0	0%	1	33%	1	33%
Opioid Use Disorders	6	2%	0	0%	0	0%	1	17%	5	83%
Pharmacy Benefits	14	4%	3	21%	0	0%	0	0%	11	79%
Pharmacy Services/Formulary Issues	105	29%	23	22%	12	11%	0	0%	70	67%

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Physician Services	46	13%	16	35%	0	0%	2	4%	28	61%
Preventive Care	1	0%	1	100%	0	0%	0	0%	0	0%
PT, OT, ST Services	6	2%	0	0%	1	17%	0	0%	5	83%
Rehabilitative/habilitative Care	1	0%	0	0%	1	100%	0	0%	0	0%
Skilled Nursing Facility Care Services	5	1%	3	60%	1	20%	0	0%	1	20%
Transportation Services	1	0%	0	0%	0	0%	0	0%	1	100%
Totals	**365**	**100%**	**118**	**32%**	**46**	**13%**	**8**	**2%**	**193**	**53%**

HEAU Cases
Subject of Complaints

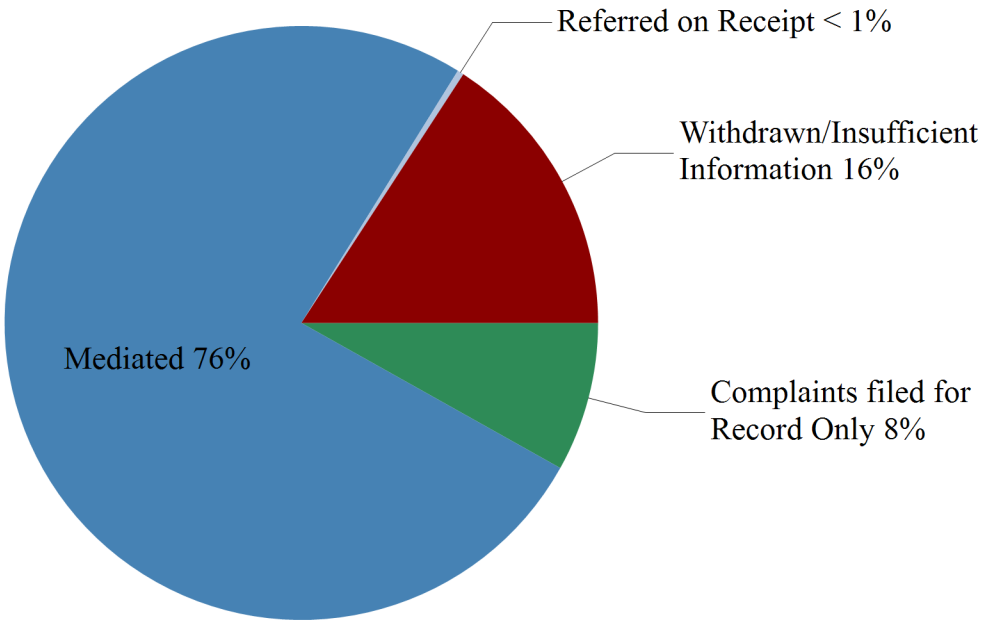
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, and various other issues encountered in the health care marketplace. The HEAU also 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 2017. The HEAU closed 2,487 complaints. Some complaints were filed against more than one industry.



* "Other" includes Collection/Billing Entities (1.5%), Government Agency (.6%), Ambulance (.8%), and other non-specific categories (e.g. Employer).

HEAU Appeals and Grievances Cases
Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Some consumers, or other persons, file complaints but never complete an authorization to release medical records, a form required by the HEAU to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. The chart below details the initial disposition of the 1,145 Appeals and Grievances cases closed by the HEAU during FY 2017.



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 2017. "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 867 cases in FY 2017. 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	10	5	50%	5	50%
Not State Regulated	47	34	72%	13	28%
Total Complaints	**57**	**39**	**68%**	**18**	**32%**
All Savers Insurance Co.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Allegeant					
Not State Regulated	4	4	100%	0	0%
Total Complaints	**4**	**4**	**100%**	**0**	**0%**
Ameritas Life Insurance Corp.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Anthem Blue Cross and Blue Shield					
Not State Regulated	26	20	77%	6	23%
Total Complaints	**26**	**20**	**77%**	**6**	**23%**
Anthem Blue Cross Blue Shield of Colorado					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Anthem Blue Cross Blue Shield of Indiana					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Anthem Blue Cross of California					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Anthem UM Services, Inc.					
Not State Regulated	10	7	70%	3	30%
Total Complaints	**10**	**7**	**70%**	**3**	**30%**
APS Healthcare Bethesda, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
APWU Health Plan					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Assurant Health					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Beacon Health Options					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Benefit Plan Administrators, Inc.					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Blue Cross Blue Shield of Illinois					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield of Michigan					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Blue Cross Blue Shield of Minnesota					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
BlueCross BlueShield of North Carolina					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CareFirst					
State Regulated	182	72	40%	110	60%
Not State Regulated	89	49	55%	40	45%
Total Complaints	**271**	**121**	**45%**	**150**	**55%**
CareFirst Administrators					
Not State Regulated	13	8	62%	5	38%
Total Complaints	**13**	**8**	**62%**	**5**	**38%**
CareFirst the Dental Network					
State Regulated	7	1	14%	6	86%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**8**	**2**	**25%**	**6**	**75%**
CIGNA					
State Regulated	16	6	37.5%	10	62.5%
Not State Regulated	75	32	43%	43	57%
Total Complaints	**91**	**38**	**42%**	**53**	**58%**
Cigna Dental					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Cigna Healthspring					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Consolidated Health Plans					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
CoreSource					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Coventry Health Care					
State Regulated	2	2	100%	0	0%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**3**	**3**	**100%**	**0**	**0%**
CVS Caremark					
State Regulated	9	2	22%	7	78%
Not State Regulated	11	5	45%	6	55%
Total Complaints	**20**	**7**	**35%**	**13**	**65%**
Delta Dental					
State Regulated	3	0	0%	3	100%
Not State Regulated	2	0	0%	2	100%
Total Complaints	**5**	**0**	**0%**	**5**	**100%**
Delta Dental of Pennsylvania					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Dominion National					
State Regulated	2	0	0%	2	100%
Not State Regulated	4	0	0%	4	100%
Total Complaints	**6**	**0**	**0%**	**6**	**100%**
Empire Blue Cross Blue Shield					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Evergreen Health Cooperative, Inc.					
State Regulated	14	3	21%	11	79%
Total Complaints	**14**	**3**	**21%**	**11**	**79%**
EviCore Healthcare					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Express Scripts					
State Regulated	1	0	0%	1	100%
Not State Regulated	9	1	11%	8	89%
Total Complaints	**10**	**1**	**10%**	**9**	**90%**
Golden Rule Insurance					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Government Employees Health Association (GEHA)					
Not State Regulated	9	7	78%	2	22%
Total Complaints	**9**	**7**	**78%**	**2**	**22%**
Group Benefit Services, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Group Dental Service of Maryland, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Guardian Life insurance Company of America					
State Regulated	3	2	67%	1	33%
Not State Regulated	2	1	50%	1	50%
Total Complaints	**5**	**3**	**60%**	**2**	**40%**
HealthSCOPE Benefits					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

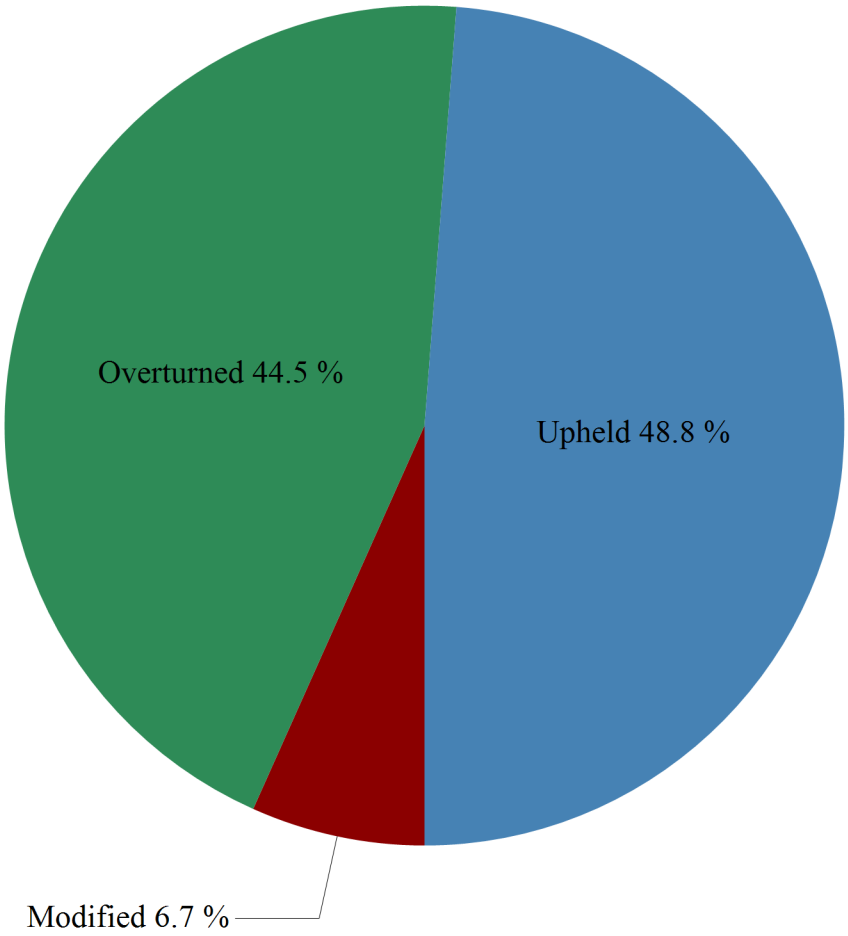
Carrier	Total Cases	Upheld		Overturned/Modified	
Horizon Blue Cross Blue Shield of New Jersey					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Humana Health Insurance					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
INTEGRA Administrative Group					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Johns Hopkins Employer Health Programs					
Not State Regulated	10	0	0%	10	100%
Total Complaints	**10**	**0**	**0%**	**10**	**100%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	44	21	48%	23	52%
Not State Regulated	6	4	67%	2	33%
Total Complaints	**50**	**25**	**50%**	**25**	**50%**
Key Benefit Administrators					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Maryland Health Connection					
State Regulated	22	5	23%	17	77%
Total Complaints	**22**	**5**	**23%**	**17**	**77%**
Maryland Health Insurance Plan (MHIP)					
State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
MDIPA					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**

Carrier	Total Cases	Upheld		Overturned/Modified	
MedSolutions					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Meritain Health Incorporated					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Metlife Dental Claims					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Metropolitan Life Insurance Company					
State Regulated	1	0	0%	1	100%
Not State Regulated	4	2	50%	2	50%
Total Complaints	**5**	**2**	**40%**	**3**	**60%**
National Claims Administrative Services					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Optum Health Care Solutions					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Significa Benefit Services					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Starmark					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Symetra Life Insurance Co.					
State Regulated	1	0	0%	1	100%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Trustmark Insurance Company					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
UMR, Inc.					
Not State Regulated	3	3	100%	0	0%
Total Complaints	**3**	**3**	**100%**	**0**	**0%**
United Behavioral Health					
State Regulated	1	1	100%	0	0%
Not State Regulated	3	0	0%	3	100%
Total Complaints	**4**	**1**	**25%**	**3**	**75%**
United Concordia Companies, Inc.					
State Regulated	5	1	20%	4	80%
Not State Regulated	29	18	62%	11	38%
Total Complaints	**34**	**19**	**56%**	**15**	**44%**
UnitedHealthcare					
State Regulated	87	36	41%	51	59%
Not State Regulated	98	58	59%	40	41%
Total Complaints	**185**	**94**	**51%**	**91**	**49%**

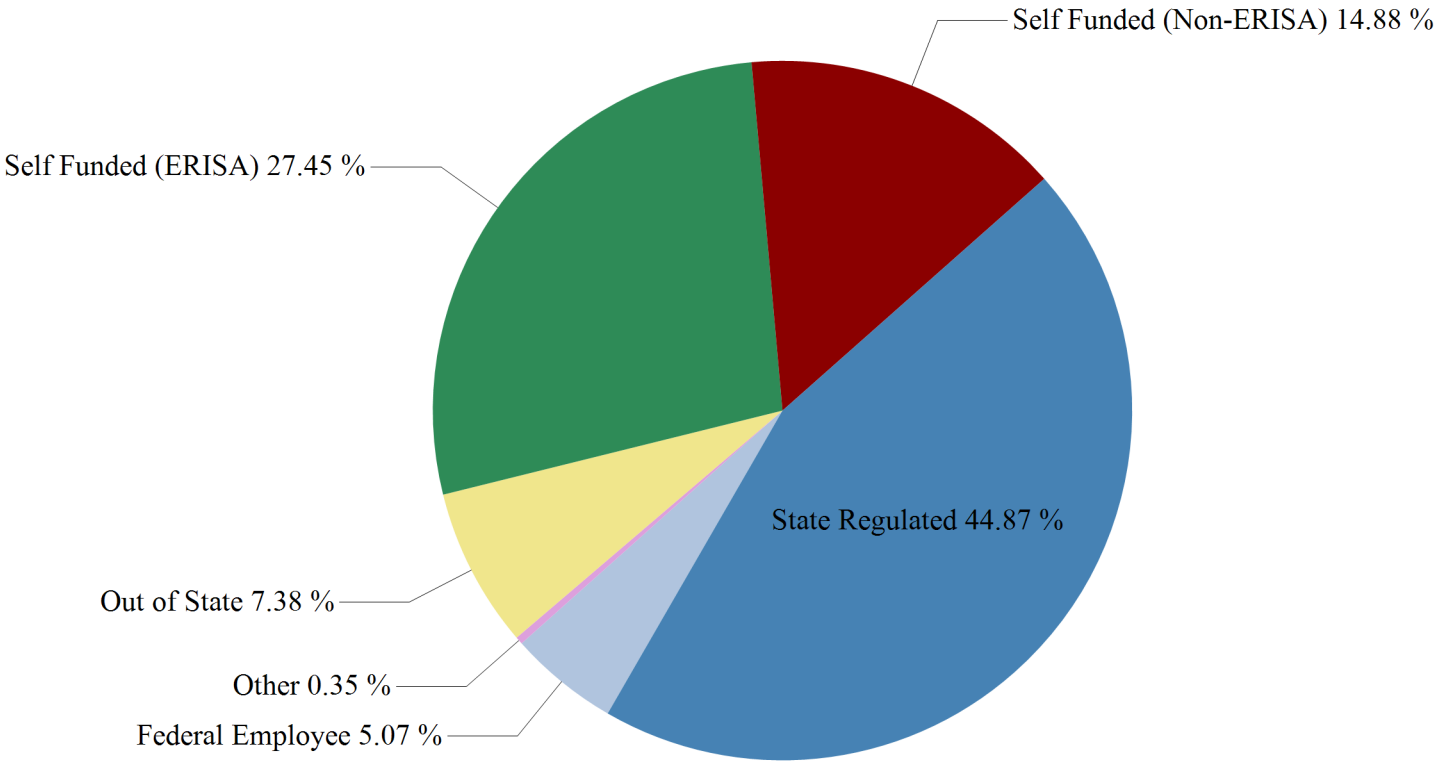
HEAU Mediated Appeals and Grievances Cases
Disposition

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 2017.



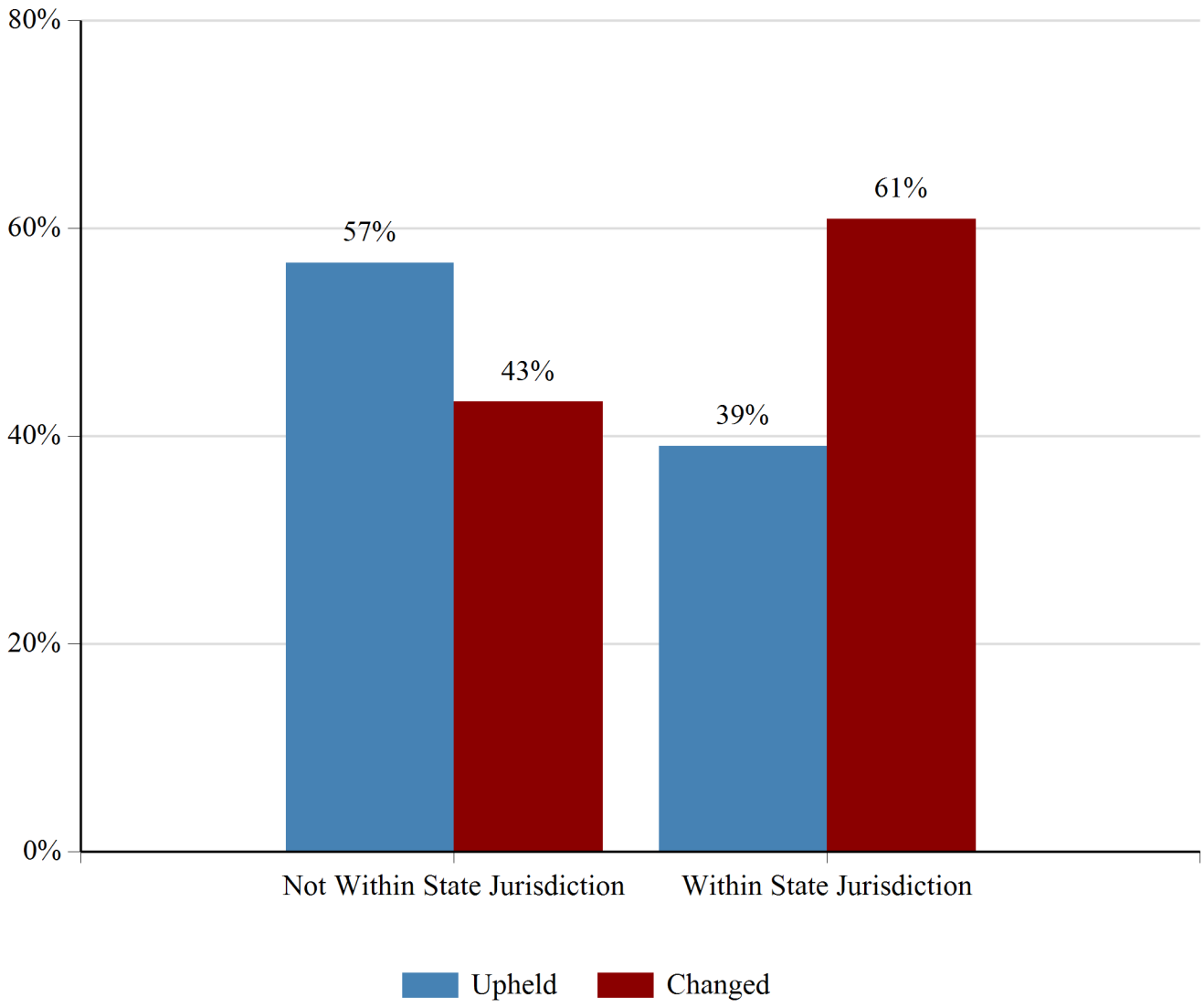
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the primary carrier types involved in the 867 Appeals and Grievances cases the HEAU mediated and closed during FY 2017.



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

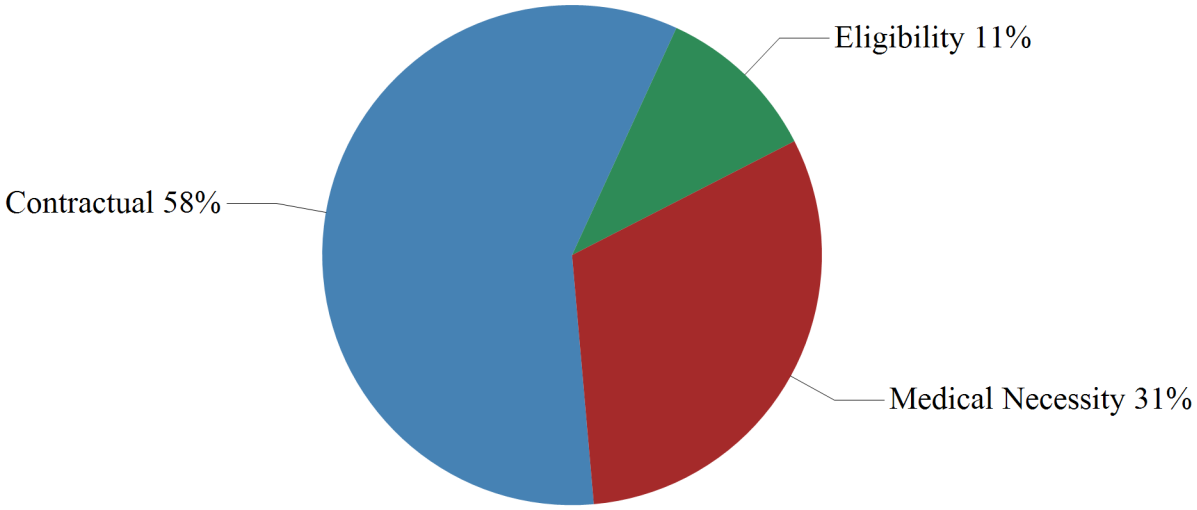
The chart below reflects the outcomes of the 867 Appeals and Grievances cases the HEAU mediated and closed during FY 2017 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

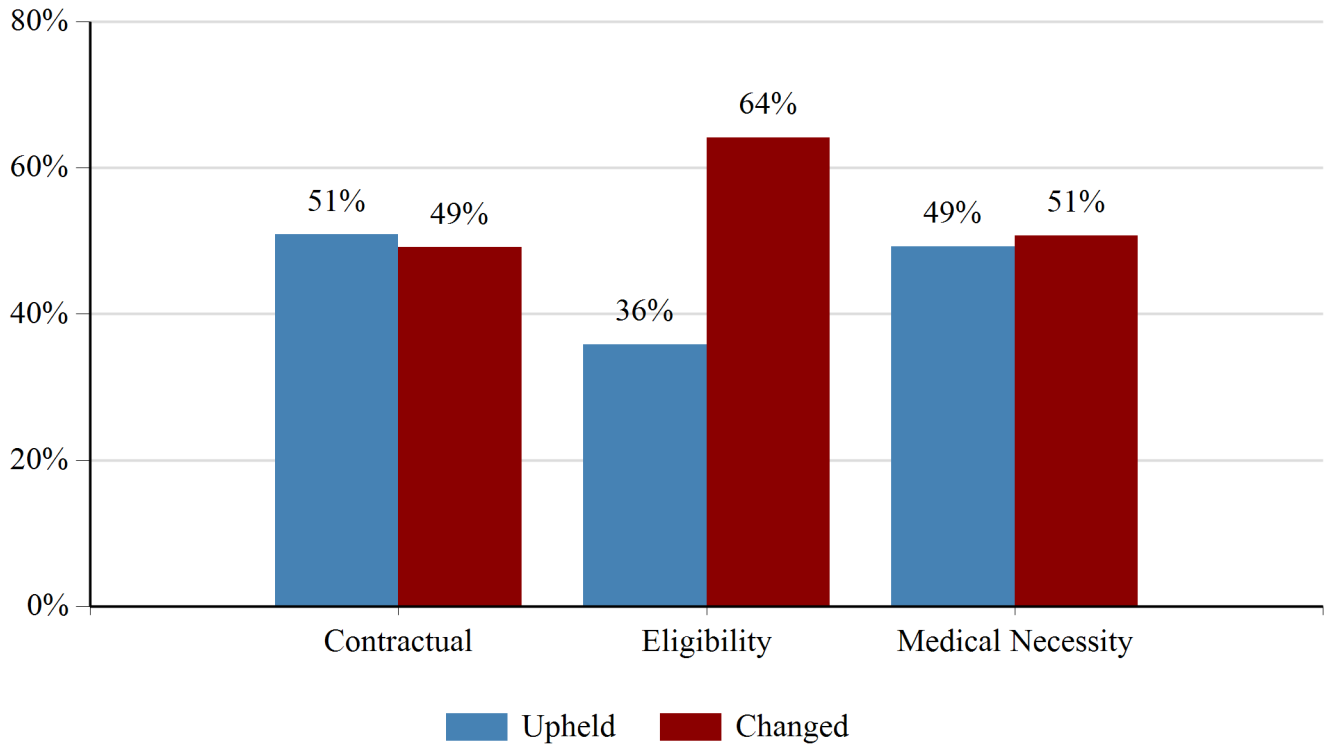
Types of Denials

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 2017.



Outcomes by Denial Type

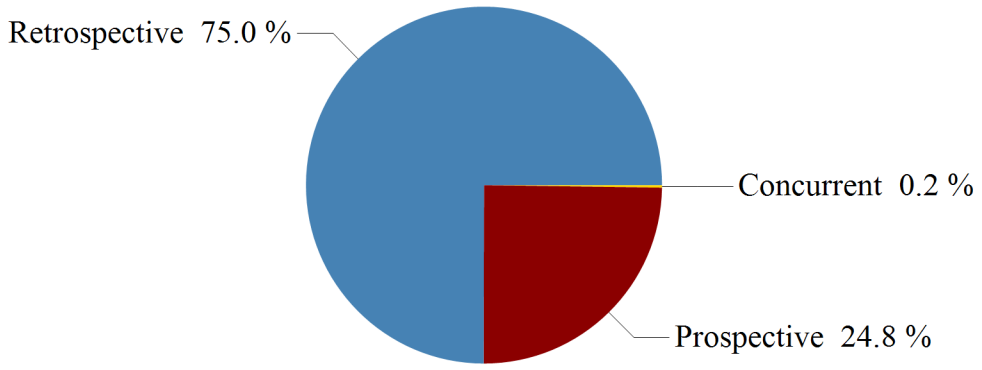
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2017.



HEAU Mediated Appeals and Grievances Cases

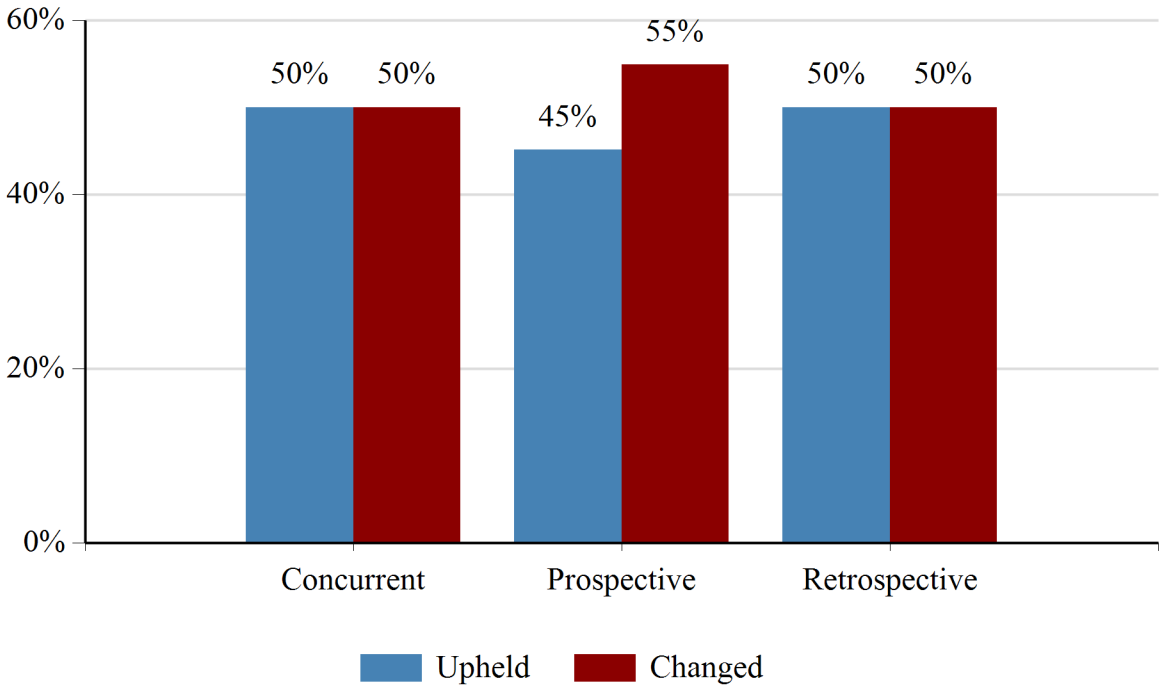
Timing of Denials

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 2017. Eligibility disputes are treated as prospective denials.



Outcomes by Timing of Denials

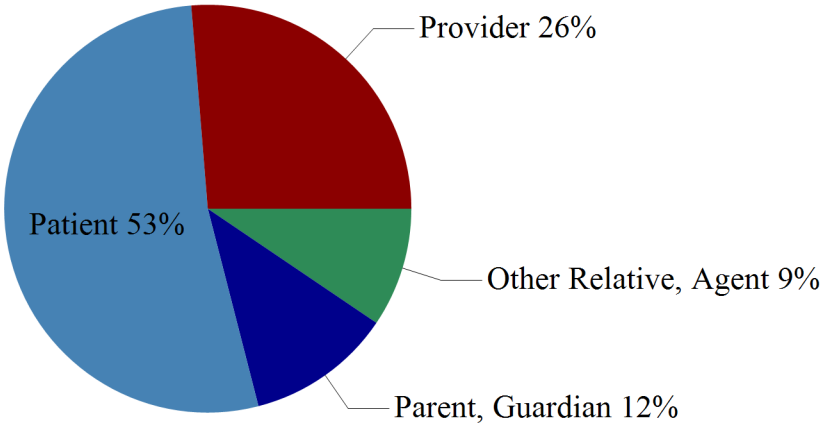
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2017 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

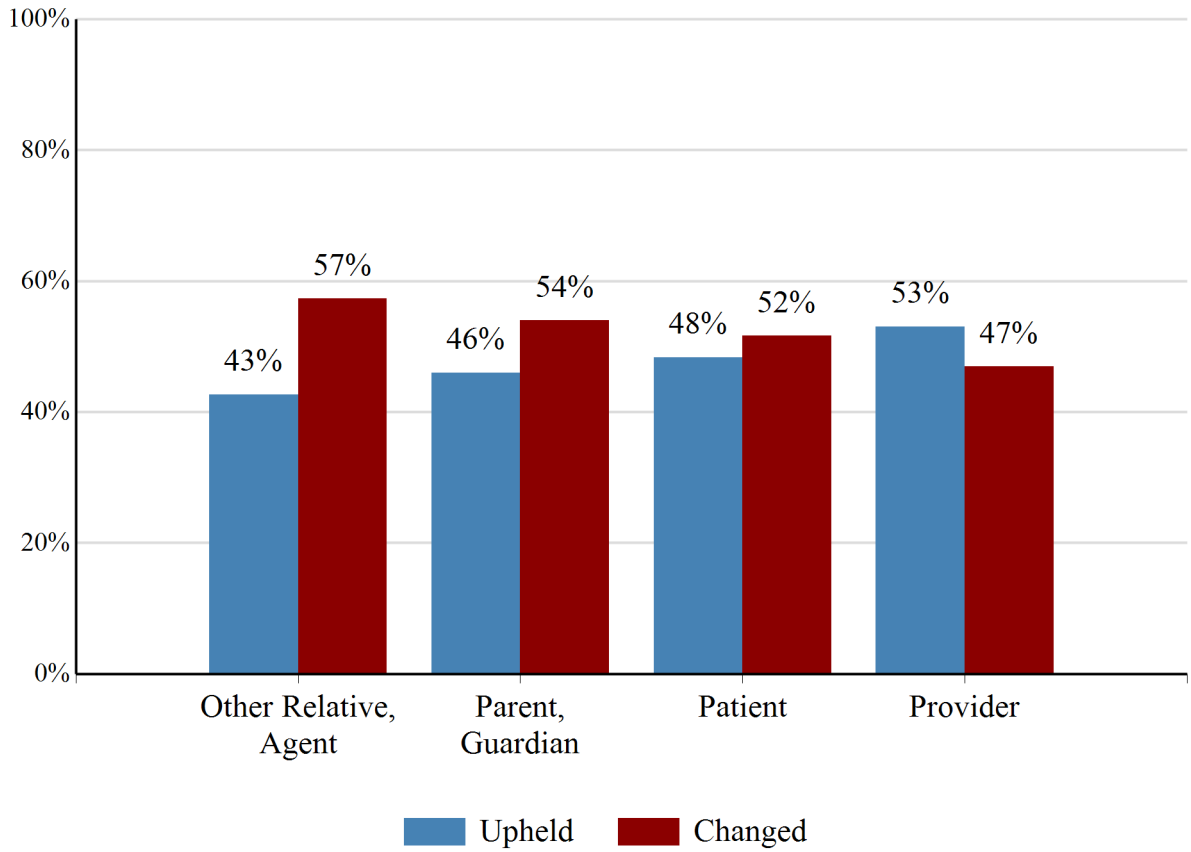
Who Filed the Case

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 2017.



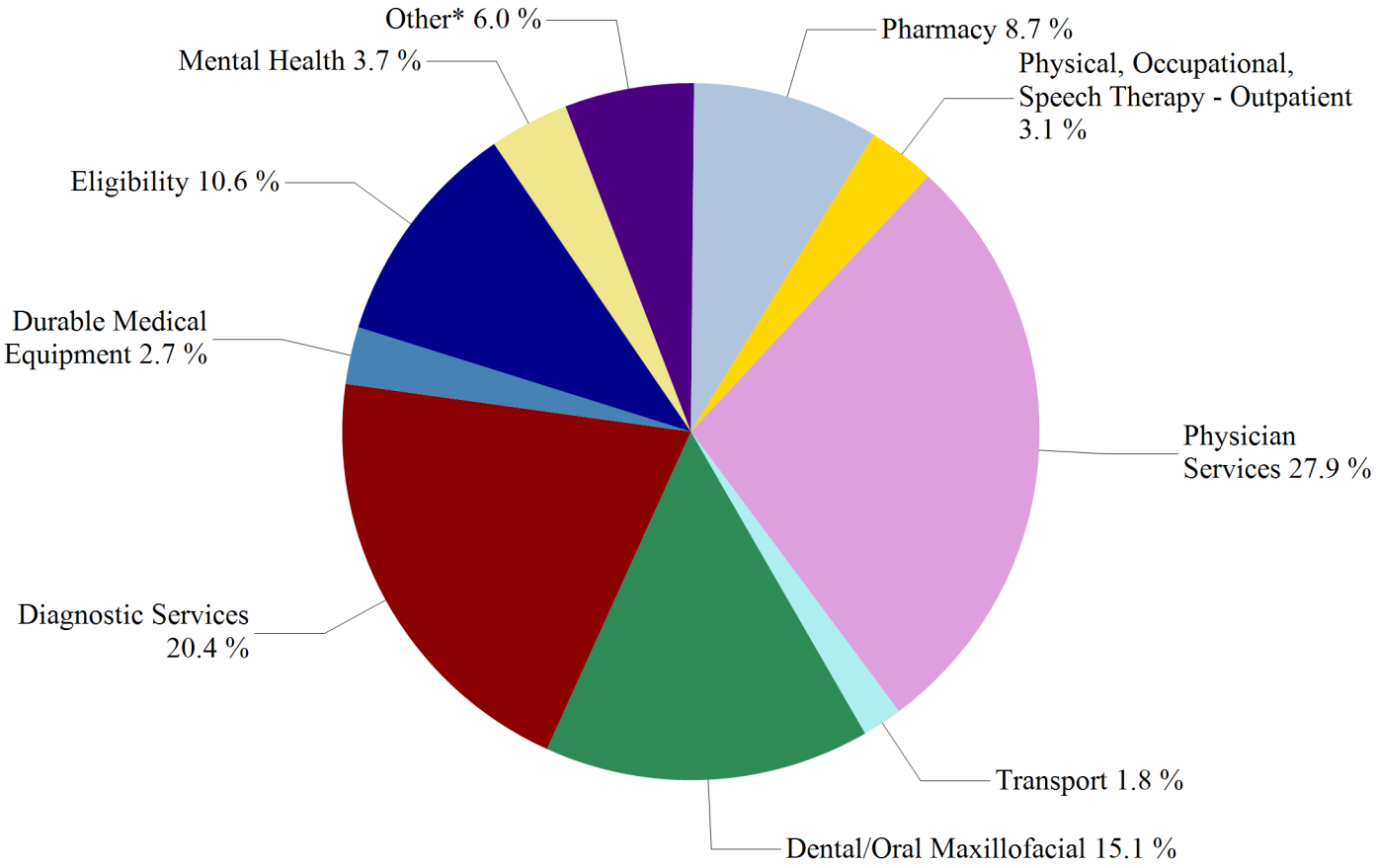
Outcomes by Who Filed the Case

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 2017.



HEAU Mediated Appeals and Grievances Cases
Types of Services Denied

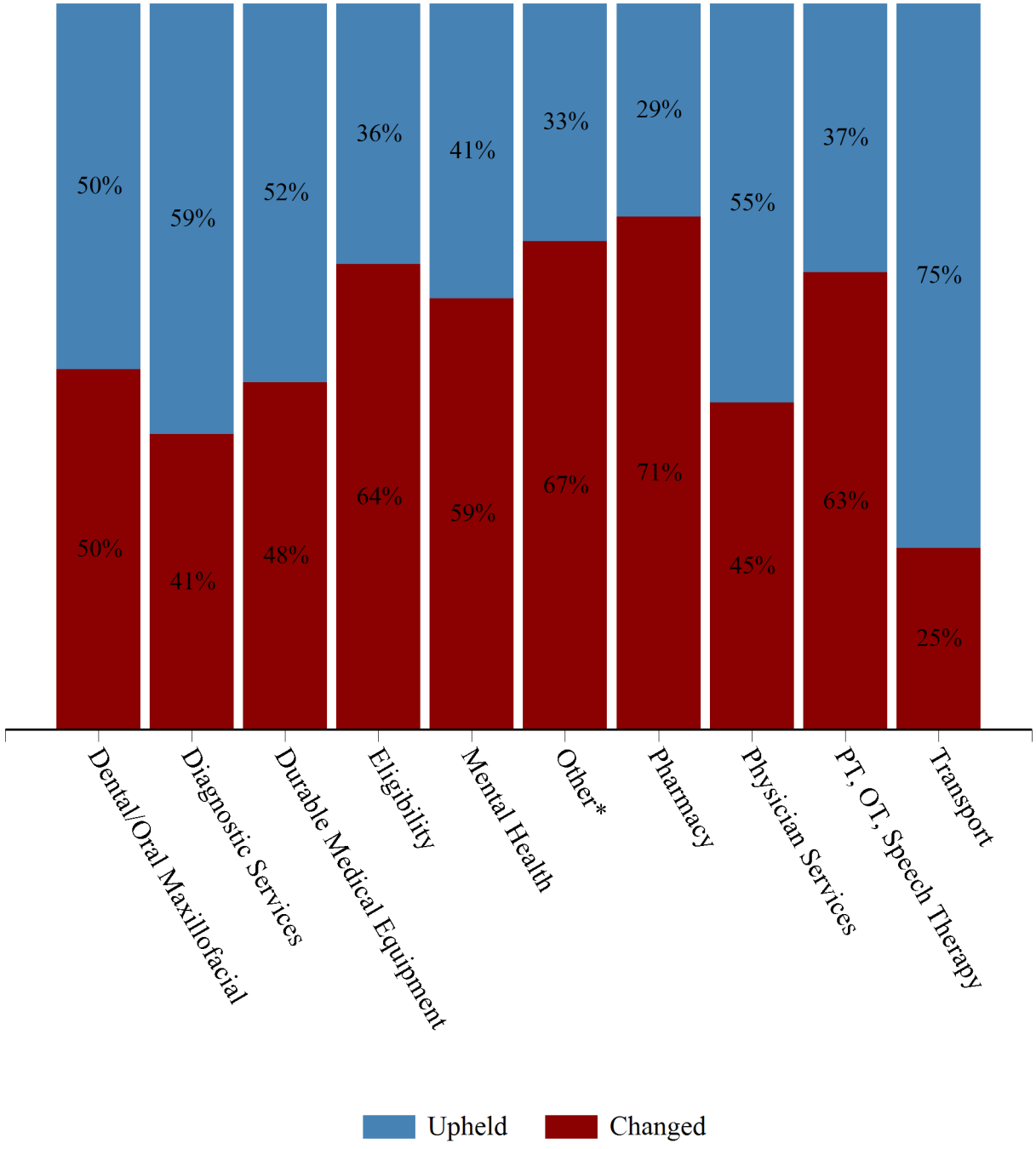
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2017.



* "Other" includes acupuncture, chiropractic, emergency room, home health, hospital length of stay, optometry, podiatry, skilled nursing facility, substance abuse, 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 2017 based on the types of services denied.



* "Other" includes acupuncture, chiropractic, emergency room, home health, hospital length of stay, optometry, podiatry, skilled nursing facility, substance abuse, and other non-specific categories (e.g. birthing class).