State of Maryland
OFFICE OF THE ATTORNEY GENERAL

ANNUAL REPORT ON THE HEALTH INSURANCE CARRIER APPEALS AND GRIEVANCES PROCESS

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I. Executive Summary

The Health Education and Advocacy Unit (the "HEAU") of the Office of the Attorney General's Consumer Protection Division submits this annual report on the implementation of the Health Insurance Carrier Appeals and Grievances Law[1] (the "Appeals and Grievances Law") as required by the Maryland Insurance Article §15-10A-08 and the Maryland Commercial Law Article §13-4A-04. Section 15-10A-08(b)(1) of the Maryland Insurance Article requires the HEAU to publish annually a summary report on the grievances and complaints filed with or referred to a carrier, the Commissioner of the Maryland Insurance Administration (the "MIA"), the HEAU, or any other federal or State government agency or unit during the previous fiscal year. Section 15-10A-08(b)(2) of the Maryland Insurance Article also requires the HEAU to evaluate the effectiveness of the internal grievance process and complaint process available to members, and to include in its annual summary report the results of this evaluation and any proposed changes that the HEAU considers necessary.

This report covers grievances and complaints filed or referred during State Fiscal Year 2020, beginning July 1, 2019 and concluding June 30, 2020.

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

II. Overview of the Appeals and Grievances Process

State Law

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

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

[1] Md. Code Ann., Insurance §15-10A-01 through §15-10A-10.
[2] The Appeals and Grievances Law defines "carrier" as (1) an authorized issuer that provides health insurance in the State, (2) nonprofit health service plan, (3) health maintenance organization, (4) dental plan, or (5) any other person that offers a health benefit plan subject to regulation by the State.
[3] Md. Code Ann., Insurance §15-10D-01 through §15-10D-04.
[4] Chapters 3 and 4 made other changes to processes and rights under the Appeals and Grievances Law that became effective July 1, 2011.

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

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

Federal Law

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

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

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

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

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

III. Phases of the Appeals and Grievances Process

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

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

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

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

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

IV. Carrier Reporting

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

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

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

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

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

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

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

Carrier Statistics FY 2020

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

1. Carriers reported 75,032 adverse decisions in FY 2020, 172 fewer adverse decisions than reported in FY 2019. For only the second year since FY 2013, but the second consecutive year, the number of adverse decisions issued by carriers has decreased. Unfortunately, several carriers increased the number of adverse decisions issued in FY 2020 over FY 2019. Notably, in FY 2020, Ameritas Life Insurance Corp. issued 71% more adverse decisions than in FY 2019; CareFirst of Maryland, Inc. issued 13% more adverse decisions than in FY 2019; CIGNA Health and Life Insurance Company issued 5% more adverse decisions than in FY 2019; Dominion Dental Services, Inc. issued 54% more adverse decisions than in FY 2019; Johns Hopkins HealthCare LLC issued 29% more adverse decisions than in FY 2019; Metropolitan Life Insurance Company issued 18% more adverse decisions than in FY 2019; UnitedHealthcare Insurance Company issued 19% more adverse decisions than in FY 2019; and UnitedHealthcare of the Mid-Atlantic, Inc. issued 16% more adverse decisions than in FY 2019.

2. The carriers administratively reversed only 277 of the reported adverse decisions, less than 1%.

3. In FY 2020, consumers filed 7,324 grievances, a 14% decrease from 8,547 grievances filed in FY 2019.

4. Like FY 2019, the largest percentage of grievances filed were in the pharmacy (50%), dental (24%), lab/radiology (9%) and physician (7%) service categories.

5. Overall, in FY 2020, during the internal grievance process, carriers altered 56% of their original adverse decisions, overturning 52% of their adverse decisions and modifying 4%.

6. Adverse decisions involving mental health/substance abuse services continue to be overturned or modified infrequently. In FY 2020, carriers reported an overturned or modified rate of 19% for mental health and substance abuse services. This rate was lower than the 34% overturned or modified rate in FY 2019. Reversal rates in prior years include: 25% in FY 2018 and 2017, 19% in FY 2016, 42% in FY 2015, 31% in FY 2014, 27% in FY 2013 and 23% in FY 2012.

7. In FY 2020, dental decisions were overturned 56% of the time. Adverse decisions involving pharmacy claims are the most likely to be overturned as reflected in a five-year review of data: 63% in FY 2020, 59% in FY 2019, 60% in FY 2018, 65% in FY 2017, and 71% in FY 2016.

8. In FY 2020, inpatient hospital service decisions were overturned 51% of the time.

V. Maryland Insurance Administration (MIA)

The MIA has regulatory oversight of insurance products offered in Maryland. In 1998, the Appeals and Grievances Law was enacted by the General Assembly to provide a fair process for resolving disputes regarding the medical necessity of a proposed or delivered health care service. (See Title 15, Subtitle 10A of the Insurance Article) Until July 1, 2011, the Appeals and Grievances law applied only to individuals with insured health benefits. However, because of the ACA expansion of external appeal rights, effective July 1, 2011, the Department of Budget and Management for the State of Maryland and, effective June 28, 2013, Cecil County Public Schools voluntarily elected to use the Maryland Insurance Administration's external review process to provide external review for their self-funded employee health benefit plans.[8]

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

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

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

documentation, the case is copied and forwarded to an Independent Review Organization ("IRO") for medical necessity review. In selecting an IRO, the MIA ensures that the IRO has an appropriate board-certified physician available to review the case. Upon receipt of the case from the MIA, the IRO then transmits the case to its expert reviewer who researches and reviews the case, renders an opinion, and transmits the opinion back to the IRO. The IRO, in turn, conducts a quality review of the expert reviewer's opinion. For medical necessity reviews, the MIA asks the IRO to respond to specific questions as set forth in a cover letter attached to the complaint. The IRO will orally inform the MIA of the expert reviewer's determination and follow up with the written determination via facsimile, first-class mail or electronic mail. If the IRO reviewer's recommendation is to overturn, uphold or modify the carrier's denial, the MIA may accept this recommendation and base its final closing letter on the professional judgment of the IRO reviewer. The complainant may be notified in writing of the outcome by electronic mail, U.S. mail, or via facsimile. The MIA also forwards a copy of the IRO's medical opinion and invoice to the carrier via facsimile and U.S. mail. In all instances, the carrier that is the subject of the complaint must pay the expenses of the IRO selected by the MIA. Hearing rights to contest the MIA decision are given to all consumers, 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 2020

MIA-provided data are reported on the charts and tables contained on pages 26-33 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 788 complaints in FY 2020. After reviewing these complaints, the MIA determined that 387 involved MIA-regulated adverse decisions.

2. The MIA referred 54 of those complaints to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process.

3. The MIA investigated 333 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 213 cases (64%). The MIA upheld 120 (36%) of the carrier decisions.

4. Similar to FY 2019, the largest percentages of grievances filed were in the pharmacy services/formulary issues (38%), dental care (16%), physician services (11%), and experimental (9%) categories. In FY 2020, lab, imaging and test service grievances were also included in the largest percentages of grievances filed (11%), an increase over the 5% in FY 2019.

VI. Health Education and Advocacy Unit (HEAU)

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

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

When the HEAU receives a request for assistance, the HEAU gathers basic information from the carriers related to the services or care denied. Specifically, the HEAU asks the carrier to provide a copy of the insurance contract provisions and the utilization review criteria upon which the carrier based the denial and to identify precisely which provisions or criteria the patient failed to meet. Carriers must provide requested information to the HEAU within 7 working days from the date the carrier received the request. The HEAU also gathers information about the patient's condition from the patient and his or her provider to determine if the patient meets the criteria established by the health plan and assesses whether the denial is incorrect. The HEAU presents this information to the carrier for reconsideration of the denial. Many complaints are resolved during this information exchange process. If not resolved, the HEAU will prepare and file a formal written grievance or appeal with the carrier on behalf of the patient.

If, at the conclusion of the internal appeals and grievances process, the carrier continues to deny coverage for the care, the HEAU prepares an external appeal of the carrier's decision. The HEAU forwards the case to the MIA or other external entity with a copy of all relevant medical and insurance documentation and the HEAU monitors the outcome of the external review.

HEAU Statistics FY 2020

The HEAU Appeals and Grievances data[9] are reported in the charts and tables contained on pages 34-52 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 2020.

The HEAU closed 1,821 cases in FY 2020.

1. 47% of the complaints closed by the HEAU involved "carriers" defined in this report to include insurers, nonprofit health service plans, HMOs, dental plan organizations, third-party administrators, utilization review agents, pharmaceutical benefit management companies, and any other entity that provides health benefit plans or adjudicates claims.

2. 14% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection-related issues.

3. 741 of the complaints closed by the HEAU were cases involving appeals and grievances. Not all of the 741 appeals and grievances complaints filed with the HEAU were mediated. Some consumers, or other persons acting on their behalf, file complaints but never complete an authorization to release medical records form or an authorized representative form (for Maryland Health Connection cases), which the HEAU requires to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. Of the 741 appeals and grievances cases the HEAU closed during FY 2020, 537 or 72% involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the 537 cases involved more than one carrier.

4. Of the 537 appeals and grievances cases the HEAU mediated during FY 2020, 29% were adverse decision (*medical necessity*) cases, 52% were coverage decision (*contractual exclusion*) cases, and 19% were eligibility cases.

5. The HEAU mediation process resulted in 57% of the medical necessity cases, 47% of the coverage decision cases, and 47% of the eligibility denial cases being overturned or modified.

6. HEAU mediation efforts resulted in a decision change of 52% in cases involving at least one MIA-regulated plan. In cases involving non-regulated plans, the HEAU efforts resulted in a decision change 48% of the time.

7. In FY 2020, the HEAU assisted patients in recovering or saving over $4.3 million dollars, including nearly $3.8 million in appeals and grievances cases.

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

VII. Successes and Areas of Concern

Maryland's Appeals and Grievances Law and the assistance provided by the HEAU continue to provide significant benefits to consumers. As the report indicates, 50% of carrier denials are overturned or modified when challenged by the HEAU. While this number reflects positive results for consumers who reach out to the HEAU, it suggests that carriers are inappropriately denying claims, causing significant financial and emotional burdens for consumers.

Several examples of the HEAU's day-to-day case work highlight the importance of the consumer assistance provided by the HEAU. The first example reveals the lifesaving benefits that Maryland's healthcare system may afford patients at this time and place when their insurance plans work as intended.

1. An infant was diagnosed at 2 months with a rare disorder, Spinal Macular Atrophy (SMA), because SMA had recently been added to Maryland's Newborn Screening (NBS) program. Her treating physician specializes in SMA and prescribed a gene therapy medication that cures SMA with 1 injection if administered before the infant turns 6 months old. The medication is the only known treatment to cure the disease; life expectancy without timely administration is approximately 6-9 years. Her carrier refused to authorize coverage for the treatment, instead authorizing a more conservative protocol to be administered over time. The family contacted the HEAU for assistance in appealing the denial, and we immediately filed an appeal. The treating physician had previously provided the carrier all the documentation explaining the very small window to administer the medication before permanent effects of the disease would become irreversible. The family's carrier overturned the denial and approved the medication, which cost $2,100,000.

2. Parents were billed $36,410.66 by an out-of-network neonatology group after their newborn spent 11 days in a Neonatal Intensive Care Unit (NICU). Before the mother was admitted for a scheduled C-section, she had verified that the hospital and her providers were in-network with her carrier. She was not told the neonatology group staffing the NICU was out-of-network before her newborn's emergency admission or during his 11-day stay in the NICU. When she challenged the bill, the neonatology group admitted she should have been informed, and that they did not have her signed consent for services. The family's self-funded, out-of-state carrier denied $29,335.98 of the claim and the neonatology group persistently sought payment of that balance bill amount from the parents. The HEAU appealed and mediated the dispute and the carrier overturned its partial denial, leaving the parents responsible for only $461.80, an amount within their deductible.

3. A provider for a 13-year-old born without a left hand determined that he would be a good candidate for a computerized, hi-tech prosthesis. The prosthesis is operated by a bionic implant that can be modified for age, growth, and capability to send myoelectric signals. This is one of the most advanced I-Limb systems for prostheses on the market, particularly suitable for children. The family's carrier denied authorization for the prosthesis, deeming it not medically necessary. The HEAU appealed and the carrier overturned the denial and approved the device at a cost of $183,305.

4. A mother was billed $9,254.12 by an out-of-network surgical group for a physician assistant who assisted with her obstetrical delivery at an in-network hospital. She was not informed of the group's out-of-network status or anticipated participation in her surgery before the delivery. The amount allowed by her federal employee plan was $237.60. The surgical group sent her the balance bill of over $9,000 and persistently sought payment. The HEAU appealed and mediated the dispute and the surgical group ultimately waived its balance bill.

5. A 47-year-old scientist on medical leave due to debilitating depression was prescribed a new medication for the treatment of major depressive disorder. The FDA designated its status as breakthrough but required administration by a provider instead of allowing at home use due to safety concerns. His federal employee plan preauthorized the medication, which a specialty pharmacy processed and sent to the provider who administered it to the patient. He was able to return to work after 4 weeks of treatment because his depression went into remission. The specialty pharmacy then notified him that his plan was not paying their claims ($20,000) because it was out-of-network. His plan advised him no in-network specialty pharmacy had a contract with the manufacturer of the medication. The patient said in his HEAU complaint, "I AM NOW WITHOUT ACCESS TO [A] LIFE-GIVING MEDICATION WHICH PUTS ME AT HIGH RISK OF RELAPSE INTO DEPRESSION AND POTENTIALLY SUICIDAL THAT WOULD MAKE ME A DANGER TO MYSELF." The HEAU initiated an expedited appeal and the carrier overturned the denial. Thereafter, the plan initiated a contract with the specialty pharmacy so that treatments could resume as originally preauthorized.

6. A 49-year-old Maryland resident had a severe cardiac event and was transported via air ambulance to a West Virginia cardiac care facility. The air ambulance, an out-of-network provider, filed a claim for $30,400 and was initially paid $8,220 by the patient's governmental health plan. The air ambulance provider balance billed the patient $22,180 and persistently sought payment of the balance bill. The HEAU appealed and mediated the dispute between the air ambulance provider and the carrier. Ultimately the carrier paid an additional $5,911 and the air ambulance provider waived the remaining balance bill of $16,269.

7. In compliance with instructions from her carrier and in-network vascular surgeon, a 58-year-old woman underwent vascular evaluation before being preauthorized for vascular surgery to treat severe and extremely painful varicose veins. She believed the vascular surgeon had performed the proper definitive diagnostics to meet the carrier's medical necessity requirement. After the surgeries were done, the carrier denied the claims as not medically necessary. The vascular surgeon's diagnostics were challenged on internal appeal, and the carrier upheld the denial. The HEAU sought external review and the denial was overturned, saving the consumer $28,548.53.

8. A 54-year-old patient with a long history of major depressive disorder was denied preauthorization for transcranial magnetic stimulation (TMS) as not medically necessary. The patient was referred to the HEAU, but proceeded with treatment, "out of absolute necessity," with a good response. The HEAU appealed and engaged with the carrier on issues relating to the patient's limited response to previous treatments,

including electroconvulsive therapy (ECT). The denial was ultimately overturned, saving the consumer $8,630 for the thirty-six treatments she had received.

The HEAU evaluated and addressed many marketplace concerns throughout the year, some new and some recurring. New concerns included COVID-19 testing and coverage issues and COVID-19 PPE/infection control surcharges. The HEAU continues to monitor and offer consumer-centric input to state agencies involved in health policy decision making. The HEAU's director served as a consumer representative, either as a member or in an *ex officio* capacity, on the Maryland Health Benefit Exchange's Standing Advisory Committee and Maryland Easy Enrollment Workgroup; the General Assembly's Health Insurance Consumer Protections Workgroup; and the Maryland Health Care Commission's Health Information Exchange Advisory Workgroup.

The HEAU also provided consultative and litigation support to the Office in its efforts to defend the consumer protections afforded to Marylanders by the Affordable Care Act. In addition to the Office's litigation efforts detailed in the Maryland Defense Act Report, the Office joined amicus briefs, *inter alia,* supporting State efforts to regulate pharmacy benefit managers' (PBM) drug-reimbursement rates; opposing efforts to defund Planned Parenthood; opposing efforts to roll back mandated contraceptive coverage; opposing efforts to eliminate anti-discrimination protections; opposing efforts to limit access to reproductive rights; and supporting efforts to require mandated risk-corridor payments to health plans by the federal government. In addition, the HEAU worked with the Office and others to comment on federal regulations and other policies threatening to undermine protections for the health of the residents of the State and the availability of affordable health care, and on regulations and other policies to enhance consumer protections in the health care marketplace.

We believe this year's consumer complaints reveal an enduring need for access to affordable primary and behavioral health care, which most consumers pay for with health insurance. Due in large part to the affirmative efforts of many stakeholders, health insurance affordability is improving in Maryland. But consumers cannot afford to pay out of pocket – even temporarily – for services their insurance should have paid upfront without needing to file a grievance or an appeal. As the preceding stories about two consumers with major depressive disorder and a newborn with a fatal disorder illustrate, there also can be patient safety risks inherent in consumers needing to avail themselves of the appeals and grievance process. And, access to affordable health insurance offers little help to consumers who require essential hospital-based services delivered by providers who refuse to participate in insurance networks and later balance bill consumers for their services.

The HEAU is focused on additional Areas of Concern:

A. Surprise Billing

As reflected in some of the success stories above, the HEAU continues to receive surprise billing complaints from consumers. Surprise medical bills occur when consumers are treated by out-of-network providers due to no fault of their own, or despite their best efforts to seek care in-network. These bills happen every day. One in five emergency room visits results in a surprise

medical bill.[10] An HEAU-complainant presented to the emergency room of an in-network hospital needing an emergency appendectomy. While being wheeled into surgery, an out-of-network, on-call surgeon told the patient that he was an out-of-network provider and that she would be responsible for his $15,000 bill. She was later balance billed $16,156. She wrote about her experience in a January 2020 op. ed. piece in the Washington Post.[11] This same surgeon balance billed other consumers who have reached out to the HEAU for help.

Surprise bills don't happen only in emergency settings. Even consumers who do their very best to make sure their care will be provided in-network later receive balance bills from providers they did not think to check on - like assistant surgeons, anesthesiologists, and radiologists - or for ancillary service providers like laboratories. Consumers understandably are incensed when they receive surprise bills from out-of-network hospital-based providers they were not told about and did not choose. The bills are often very high and arise out of disruptive emergencies, e.g., $36,000 for neonatology services provided to a newborn infant. While the preceding stories show that the HEAU is sometimes able to mediate surprise billing complaints successfully for consumers who file complaints, the other consumers must contend with persistent collection efforts by providers willing and able to exploit current regulatory gaps that incentivize surprise billing.

B. COVID-19 Public Health Emergency

1. COVID-19 Surcharges

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

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

Through mediation efforts, we have halted the collection and sought refunds for improperly collected fees from more than 20 providers and counting. As part of the outreach, the HEAU suggested to complaining providers that they file PPE price-gouging complaints with the Office so the emergency price-gouging prohibition enacted by the General Assembly could be enforced against offenders. The providers expressed concern about filing complaints that could disrupt their supply chain.

[10] "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills." Health Affairs. Vol 36. No. 1. 2017, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970. *See also*, Cooper, Zack and Fiona Scott Morton. "Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise" New England Journal of Medicine. 2017, https://www.nejm.org/doi/full/10.1056/NEJMp1608571.

[11] https://www.washingtonpost.com/opinions/the-health-care-industry-is-letting-surgeons-behave-like-muggers/2020/01/13/f2089094-3636-11ea-bb7b-265f4554af6d_story.html

2. COVID-19 Testing Costs and Coverage

Early in the public health emergency, the HEAU also received complaints from consumers about healthcare providers, largely urgent care centers, billing patients at the point-of-service for diagnostic COVID-19 testing in violation of federal and state laws. Our office immediately reached out to the state medical associations, and later issued a press release notifying providers and consumers that billing patients for testing in violation of state and federal laws was also a violation of the Consumer Protection Act. Through mediation efforts, we have halted the collection and sought refunds for improperly collected fees.

C. Terminations

The HEAU has received complaints from patients who are vulnerable due to age and/or behavioral health issues, about providers terminating them from community practices affiliated with hospital systems. The terminations occurred before, but of course continue through, the public health emergency. An individual provider's power to terminate a patient from an entire community practice, including all statewide locations, has been upheld by the hospital systems. The harmful consequences for terminated patients increase as the number of providers *not* affiliated with hospital systems decrease, especially outside urban areas; they struggle to find new providers. They also believe they have been discriminated against based on age and/or behavioral health issues. When mediation efforts fail, we will make referrals to the Office of Health Care Quality in accordance with newly enacted H.B. 1120/S.B. 738, 2020 Leg., 441st Sess. (Md. 2020), codified at Md. Code Ann., Health-Gen. § 2-1001 *et seq*.

D. Financial Assistance Policies and Medical Debt

The HEAU has always assisted consumers with questions or complaints about hospital financial assistance policies (FAP), and we anticipate an uptick now that hospitals must expressly inform consumers that they may obtain such assistance from the HEAU. We continue to support the medical debt legislation that was deferred at the end of last session due to the public health emergency which has also interfered with the interim workgroup. Consumers have complained about soft credit checks conducted by hospitals, evidently as part of their effort to comply with federal and state law FAP requirements. Consumers are distressed by the lack of transparency about the credit checks and we believe hospitals should notify consumers when they are run.

E. Medical Records

1. Costs

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

2. Electronic Health Record Errors

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

3. Abandoned Medical Records

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

The HEAU has also received complaints about medical practices owned by non-physicians purchasing other medical practices and abandoning medical records with impunity because the Board of Physicians cannot discipline a non-physician. Pediatric records serially abandoned over the last three years by a non-physician purchaser have generated five complaints on behalf of children whose records still have not been found. Some of the purchaser's records had been retrieved from a storage unit shortly before the contents were auctioned off due to non-payment of rent; others were retrieved from an office building as part of an eviction. The HEAU would support legislation to close current regulatory gaps that place pediatric and other records at risk.

F. Telehealth

The rapid expansion of telehealth in response to the public health emergency promises to improve network adequacy for behavioral health and other consumers, which the HEAU supports. We will continue to participate in the Network Adequacy Workgroup conducted by the Maryland Insurance Administration and other workgroups evaluating telehealth expansion, but we believe feasible, affordable, anti-fraud protections and data privacy protections must be an essential component of any telehealth program.

G. Outpatient Facility Fees – Follow Up

In an effort to protect consumers from surprising and excessive outpatient facility fees charged by hospitals (see complaints described in the 2016-2019 Annual Reports), the HEAU actively supported the successful passage of the 2020 Facility Fee Right to Know Act, effective July 1, 2021. We are also pleased that the discourse led to the Health Services Cost Review Commission's (HSCRC) commitment to the legislature that beginning July 1, 2020, evaluation and management clinic fees would be reduced approximately 25% overall, and that the HSCRC would convene a workgroup in the upcoming year to review and update other facility fees. The HSCRC confirmed to the HEAU in September that hospitals were required to lower the fees by July 1, 2020.

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

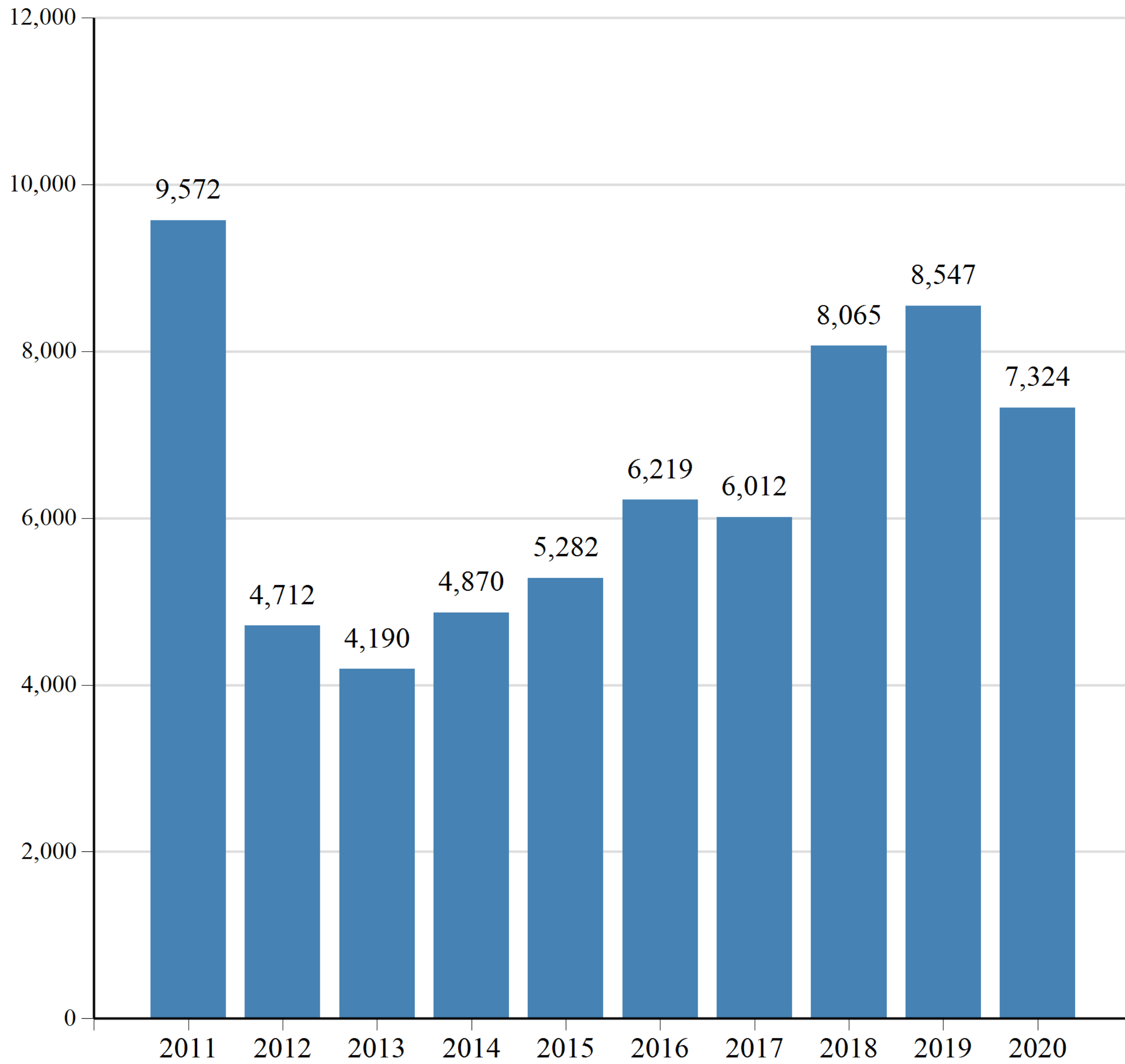
Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
4 Ever Life Insurance Company	1	0	2	0%	100%
Aetna Dental Inc.	567	0	0	0%	0%
Aetna Health Inc. (a Pennsylvania corporation)	178	25	303	48%	52%
Aetna Life Insurance Company	158	29	198	49%	51%
Ameritas Life Insurance Corp.	168	0	76	66%	34%
CareFirst BlueChoice, Inc.	19,099	0	1,826	41%	59%
Carefirst of Maryland, Inc.	9,176	0	1,028	38%	62%
CIGNA Dental Health of Maryland, Inc.	28	0	0	0%	0%
CIGNA Health and Life Insurance Company	8,586	114	548	55%	45%
Combined Insurance Company of America	0	0	1	100%	0%
Companion Life Insurance Company	0	0	1	0%	100%
Connecticut General Life Insurance Company	2	0	0	0%	0%
Delta Dental Insurance Company	8	0	0	0%	0%
Delta Dental of Pennsylvania	5	0	0	0%	0%
Dental Network, Inc.	0	0	63	16%	84%
Dominion Dental Services, Inc.	534	7	28	61%	39%
Golden Rule Insurance Company	15	0	5	80%	20%
Group Dental Service of Maryland, Inc.	3,114	0	0	0%	0%
Group Hospitalization and Medical Services, Inc.	7,609	0	821	39%	61%
Guarantee Trust Life Insurance Company	0	0	3	100%	0%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Guardian Life Insurance Company of America	743	1	456	62%	38%
Independence American Insurance Company	0	0	10	70%	30%
Johns Hopkins HealthCare LLC	72	0	129	65%	35%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	686	0	66	73%	27%
Kaiser Permanente Insurance Company	55	0	11	64%	36%
Lincoln Life & Annuity Company of New York	4	3	0	0%	0%
Lincoln National Life Insurance Company	142	34	0	0%	0%
MAMSI Life and Health Insurance Company	1,458	0	99	45%	55%
Metropolitan Life Insurance Company	457	53	36	67%	33%
National Health Insurance Company	10	0	0	0%	0%
Optimum Choice, Inc.	2,871	0	153	46%	54%
Philadelphia American Life Insurance Company	5	0	5	80%	20%
Principal Life Insurance Company	407	0	72	85%	15%
Reliance Standard Life Insurance Company	3	0	2	50%	50%
Standard Insurance Company	22	0	9	78%	22%
Standard Security Life Insurance Company of New York	0	0	1	100%	0%
Starmount Life Insurance Company	2	1	3	33%	67%
Sun Life Assurance Company of Canada	457	10	30	60%	40%
Unicare Life & Health Insurance Company	2	0	0	0%	0%
Union Security Insurance Company	450	0	32	50%	50%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
United Concordia Insurance Company	731	0	332	16%	84%
United of Omaha Life Insurance Company	15	0	13	38%	62%
UnitedHealthcare Insurance Company	15,399	0	925	39%	61%
UnitedHealthcare of the Mid-Atlantic, Inc.	1,791	0	34	41%	59%
Wellfleet Group LLC	2	0	3	100%	0%
Totals	**75,032**	**277**	**7,324**	**44%**	**56%**

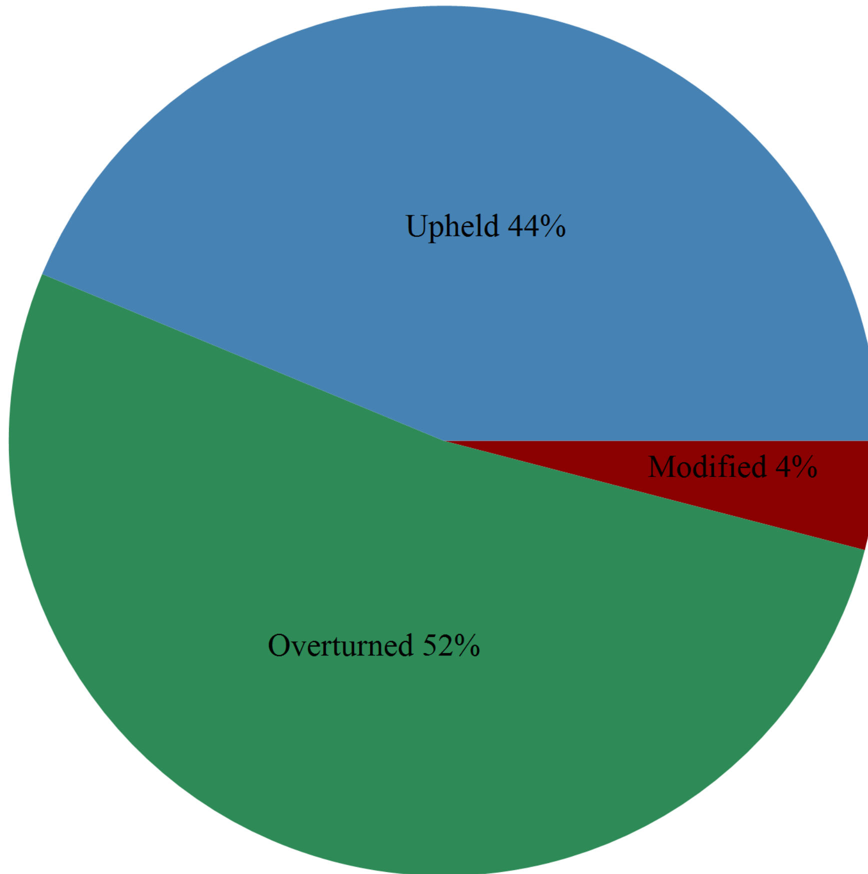
Carrier Grievances Cases
Number of Grievances Since Fiscal Year 2011

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



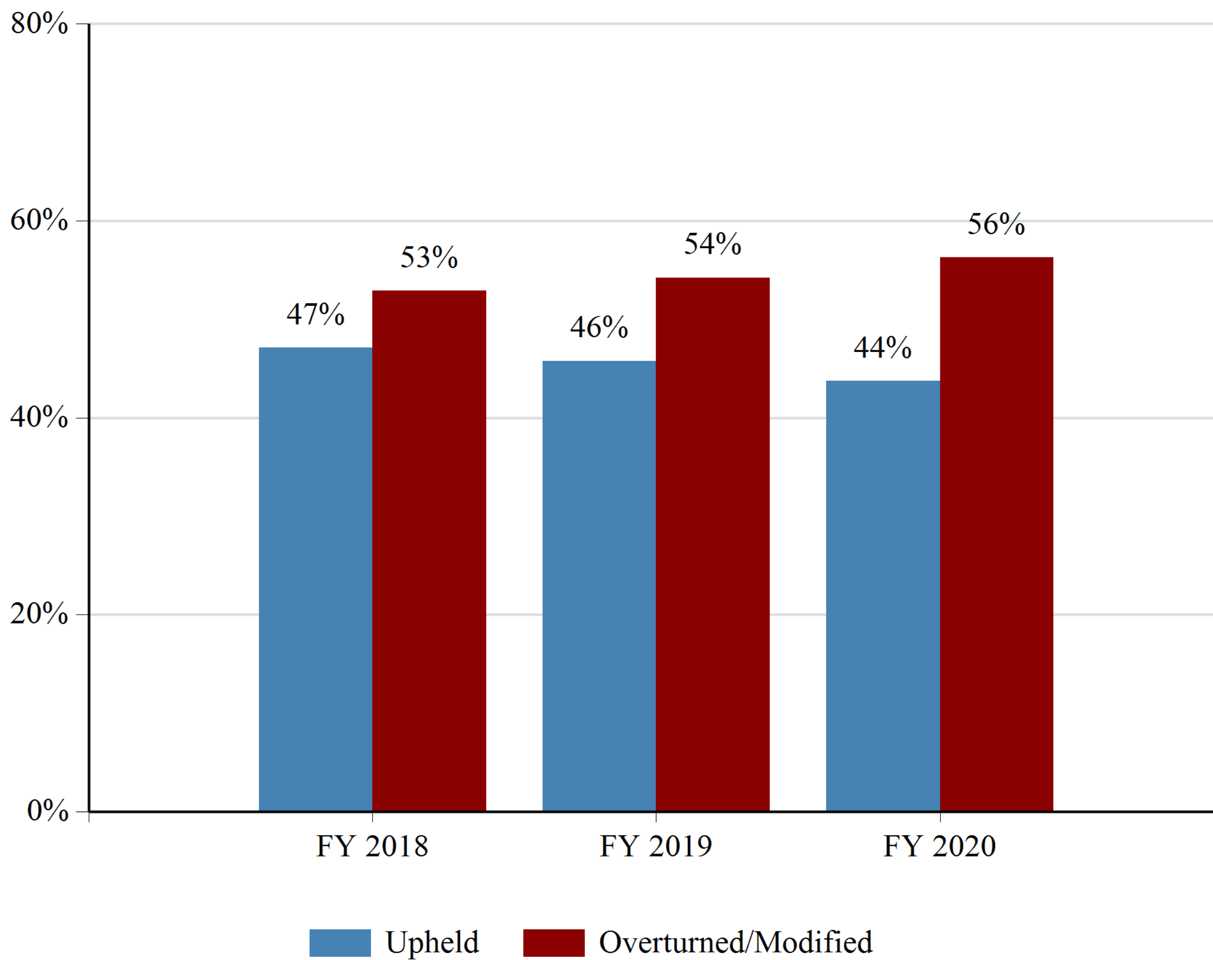
Carrier Grievances Cases
Outcomes

The chart below describes the outcomes of the 7,324 internal grievances filed with carriers in FY 2020, 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 2020, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	19,356	25.80%	1,794	24.49%
Durable Medical Equipment	1,578	2.10%	130	1.77%
Emergency Room	16	0.02%	41	0.56%
Home Health	180	0.24%	2	0.03%
Inpatient Hospital	1,199	1.60%	175	2.39%
Laboratory, Radiology	10,140	13.51%	665	9.08%
Mental Health / Substance Abuse	743	0.99%	90	1.23%
Other*	503	0.67%	186	2.54%
Pharmacy	32,614	43.47%	3,653	49.88%
Physician	4,747	6.33%	486	6.64%
PT, OT, ST, including inpatient rehabilitation	3,929	5.24%	83	1.13%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	27	0.04%	19	0.26%
Totals	**75,032**	**100%**	**7,324**	**100%**

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

Carrier Grievances Cases
Outcomes by Service Type

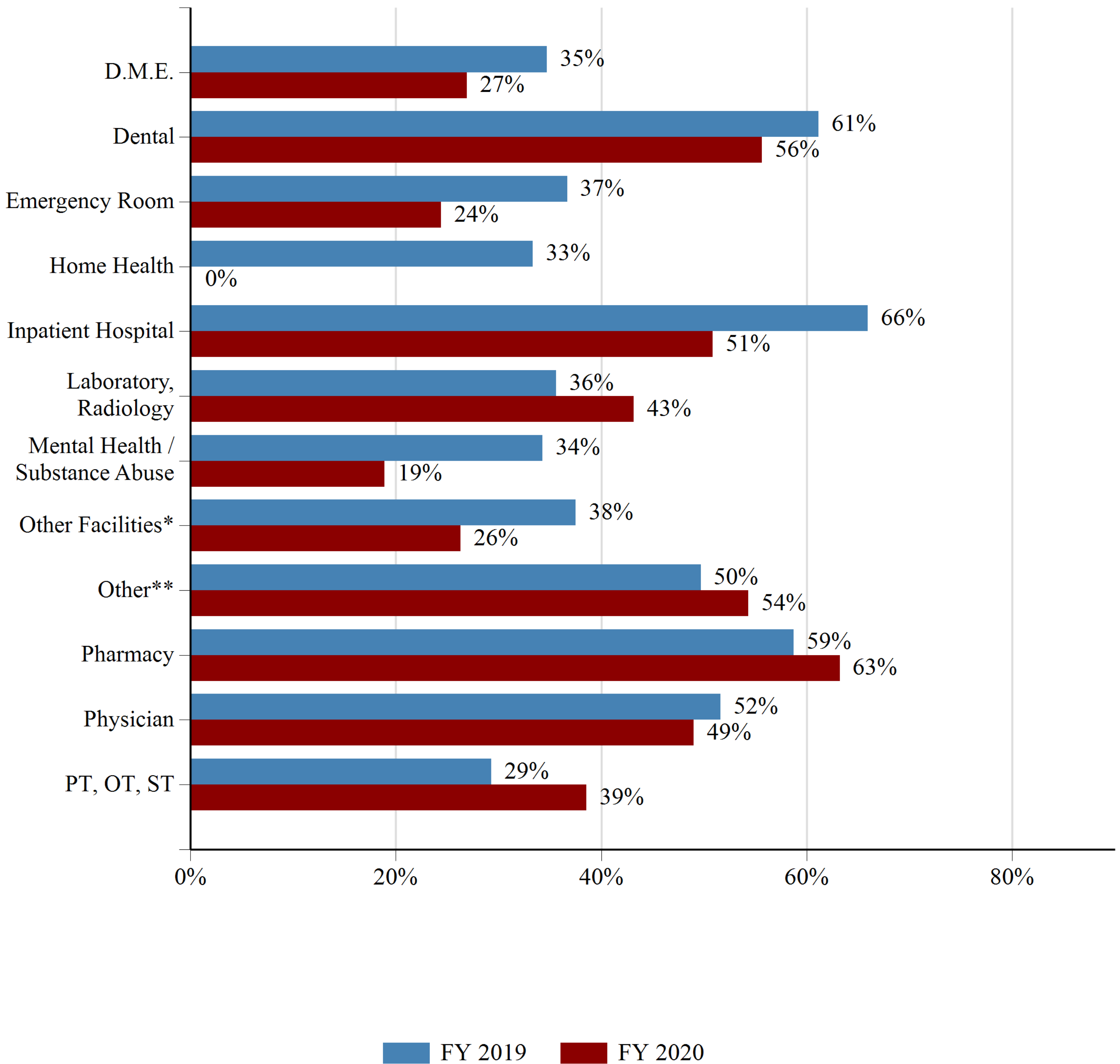
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.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

Type of Service	Total Grievances	Upheld	Overturned/ Modified
Dental	1,794	44%	56%
Durable Medical Equipment	130	73%	27%
Emergency Room	41	76%	24%
Home Health	2	100%	0%
Inpatient Hospital	175	49%	51%
Laboratory, Radiology	665	57%	43%
Mental Health / Substance Abuse	90	81%	19%
Other*	186	46%	54%
Pharmacy	3,653	37%	63%
Physician	486	51%	49%
PT, OT, ST, including inpatient rehabilitation	83	61%	39%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	19	74%	26%
Totals	**7,324**	**44%**	**56%**

*"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 2019 and FY 2020.

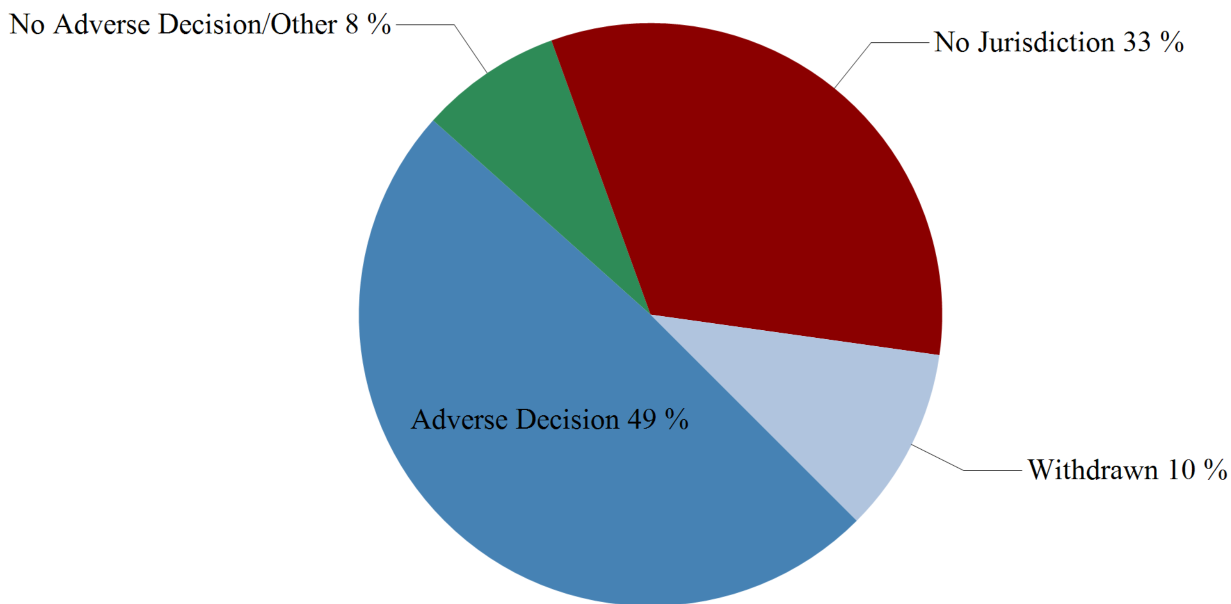


* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.
** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints
Initial Review of Cases

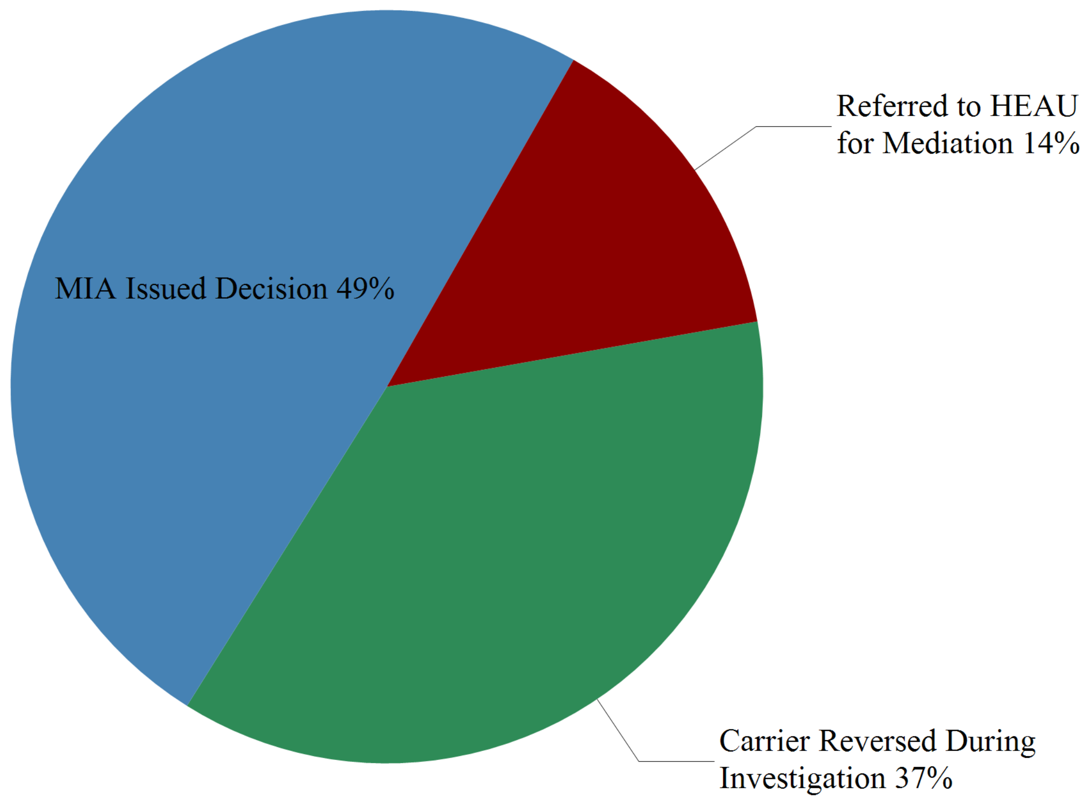
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some 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 788 cases filed with the MIA's Appeals and Grievances Unit during FY 2020.



MIA Appeals and Grievances Complaints
Initial Disposition of Grievances

During FY 2020, the MIA determined that 387 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 54 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 387 grievances the MIA reviewed during FY 2020.



MIA Appeals and Grievances Cases
Carriers and Disposition

The table below details the outcomes of the 333 grievances complaints the MIA investigated during FY 2020. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

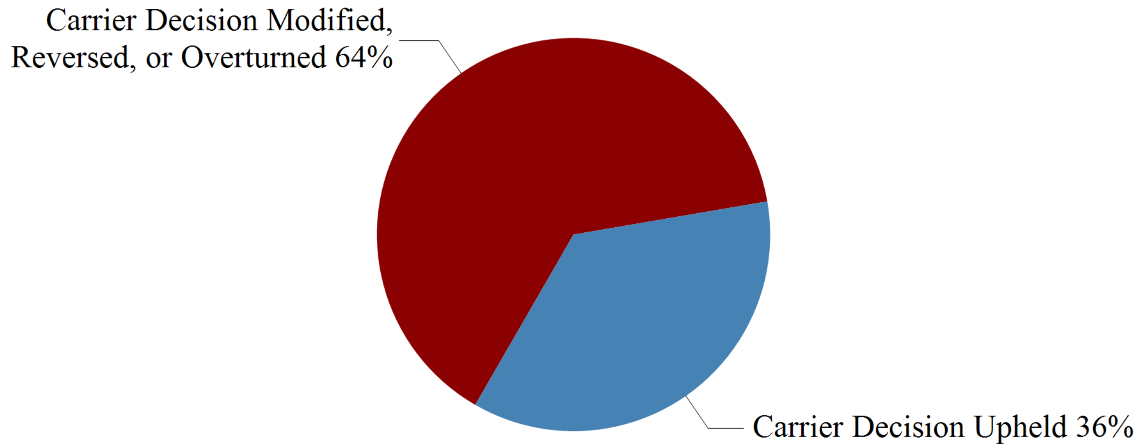
Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	6	3	50.0%	0	0.0%	0	0.0%	3	50.0%
Aetna Life Insurance Company	8	4	50.0%	2	25.0%	1	12.5%	1	12.5%
CareFirst BlueChoice, Inc.	69	29	42.0%	13	18.8%	1	1.4%	26	37.7%
Carefirst of Maryland, Inc.	85	31	36.5%	21	24.7%	0	0.0%	33	38.8%
CaremarkPCS Health L.L.C.	26	6	23.1%	5	19.2%	0	0.0%	15	57.7%
CIGNA Health and Life Insurance Company	15	10	66.7%	3	20.0%	0	0.0%	2	13.3%
Delta Dental of Pennsylvania	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Dominion Dental Services, Inc.	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
Express Scripts, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Golden Rule Insurance Company	1	0	0.0%	0	0.0%	1	100.0%	0	0.0%
Group Hospitalization and Medical Services, Inc.	13	4	30.8%	2	15.4%	0	0.0%	7	53.8%
Guardian Life Insurance Company of America	6	2	33.3%	0	0.0%	0	0.0%	4	66.7%
Humana Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
HumanaDental Insurance Company	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	8	4	50.0%	2	25.0%	0	0.0%	2	25.0%
Kaiser Permanente Insurance Company	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%

Carrier	Total Grievances	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
MAMSI Life and Health Insurance Company	2	0	0.0%	0	0.0%	0	0.0%	2	100.0%
Metropolitan Life Insurance Company	3	0	0.0%	0	0.0%	0	0.0%	3	100.0%
Optimum Choice, Inc.	8	1	12.5%	1	12.5%	0	0.0%	6	75.0%
Principal Life Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Unicare Life & Health Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
United Behavioral Health	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
United Concordia Dental Plans, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
United Concordia Insurance Company	1	0	0.0%	1	100.0%	0	0.0%	0	0.0%
United Concordia Life and Health Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Insurance Company	65	20	30.8%	16	24.6%	1	1.5%	28	43.1%
UnitedHealthcare of the Mid-Atlantic, Inc.	3	0	0.0%	1	33.3%	0	0.0%	2	66.7%
Totals	**333**	**120**	**36%**	**67**	**20%**	**4**	**1%**	**142**	**43%**

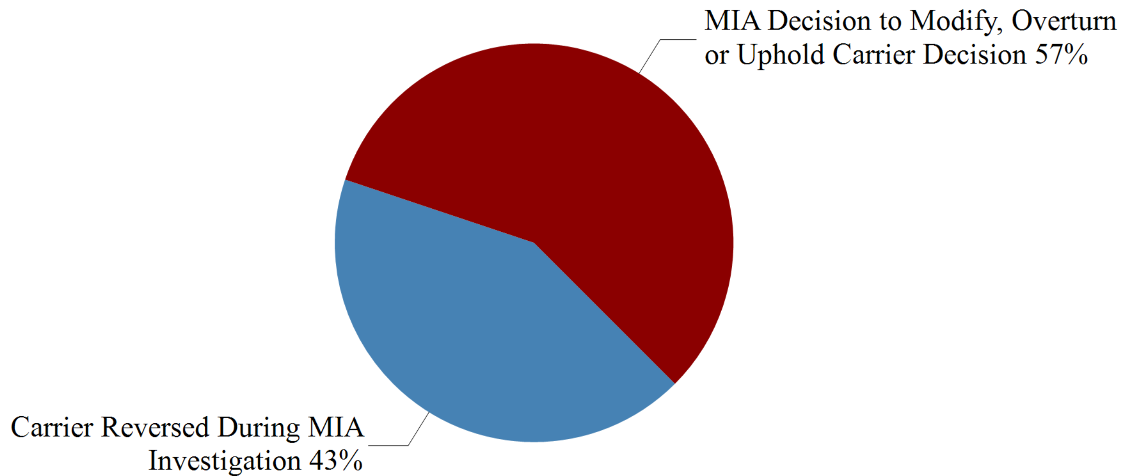
Percentages may not equal 100% due to rounding.

MIA Appeals and Grievances Cases
Disposition Following Investigation

The chart below reflects the overall outcomes of the 333 grievances the MIA investigated during FY 2020.

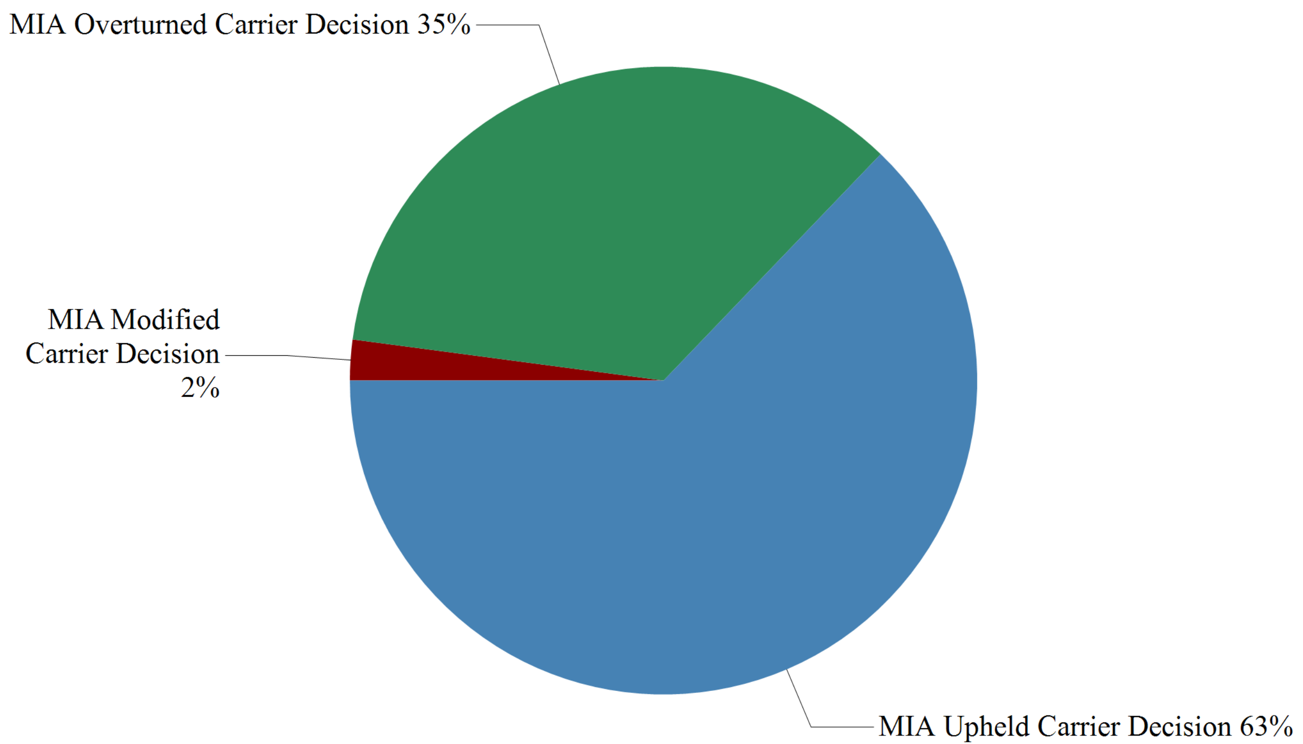


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases
Disposition Resulting from IRO Review

The chart below describes the outcomes of the 191 cases the MIA forwarded to an IRO for review in FY 2020.



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 2020. 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.

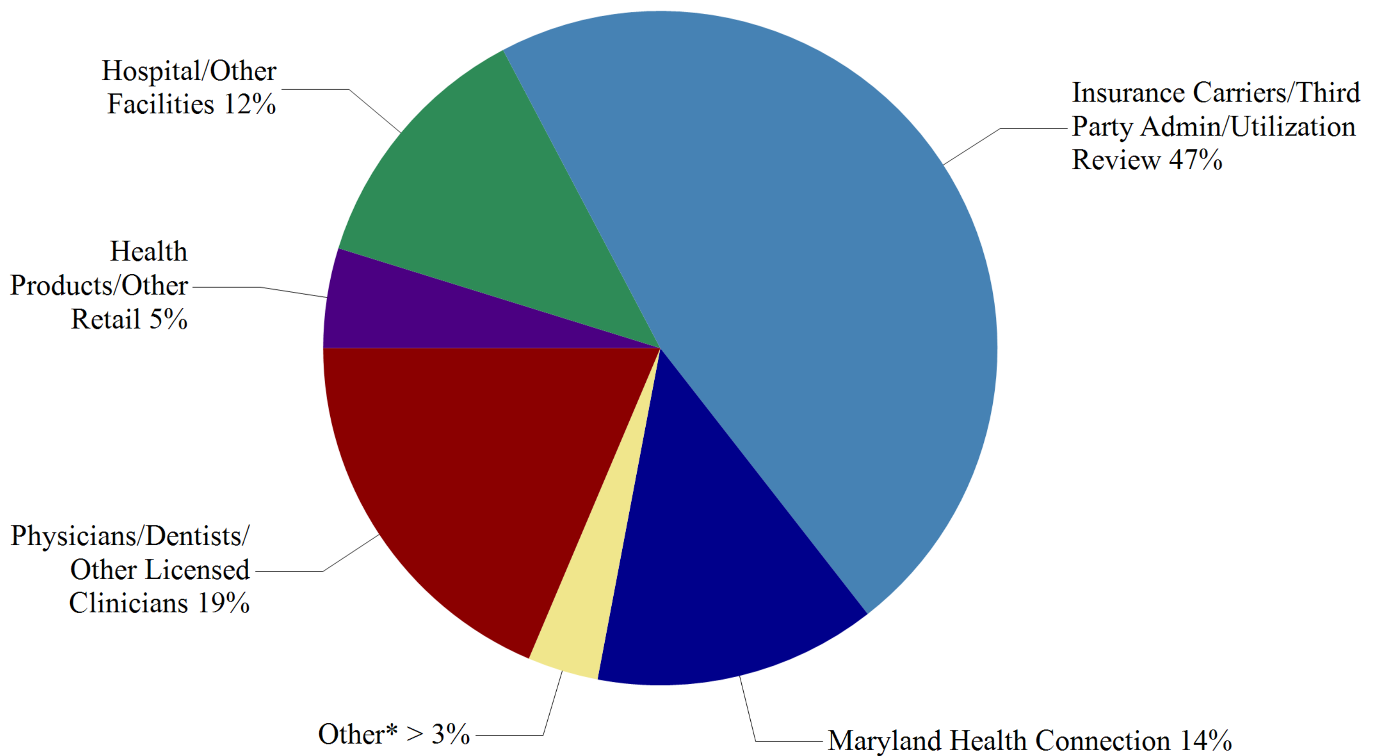
Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Air Ambulance	5	2%	3	60%	2	40%	0	0%	0	0%
Cosmetic	5	2%	0	0%	2	40%	0	0%	3	60%
COVID-19	1	<1 %	0	0%	0	0%	0	0%	1	100%
Denial of Hospital Days	2	<1 %	0	0%	2	100%	0	0%	0	0%
Dental Care Services	53	16%	24	45%	4	8%	0	0%	25	47%
Durable Medical Equipment	14	4%	6	43%	2	14%	0	0%	6	43%
Experimental	31	9%	19	61%	9	29%	0	0%	3	10%
Eye Care Services	2	<1 %	0	0%	0	0%	0	0%	2	100%
In-Patient Rehabilitation Services	2	<1 %	1	50%	0	0%	0	0%	1	50%
Lab, Imaging, Test Services	37	11%	24	65%	6	16%	0	0%	7	19%
Mental Health Partial Hospitalization	1	<1 %	1	100%	0	0%	0	0%	0	0%
Mental Health/Substance Abuse (Inpatient) Services	8	2%	1	13%	4	50%	1	13%	2	25%
Mental Health/Substance Abuse (Outpatient) Services	3	<1 %	1	33%	0	0%	1	33%	1	33%
Morbid Obesity	1	<1 %	1	100%	0	0%	0	0%	0	0%
Obesity Service	1	<1 %	1	100%	0	0%	0	0%	0	0%
Opioid Use Disorders	2	<1 %	0	0%	0	0%	0	0%	2	100%
Pharmacy Benefits	1	<1 %	1	100%	0	0%	0	0%	0	0%
Pharmacy Services/Formulary Issues	125	38%	23	18%	26	21%	0	0%	76	61%
Physician Services	37	11%	13	35%	10	27%	2	5%	12	32%

Type Of Service	Total Grievances		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
PT, OT, ST Services	2	<1 %	1	50%	0	0%	0	0%	1	50%
Totals	**333**	**100%**	**120**	**36%**	**67**	**20%**	**4**	**1%**	**142**	**43%**

Percentages may not equal 100% due to rounding.

HEAU Cases
Subject of Complaints

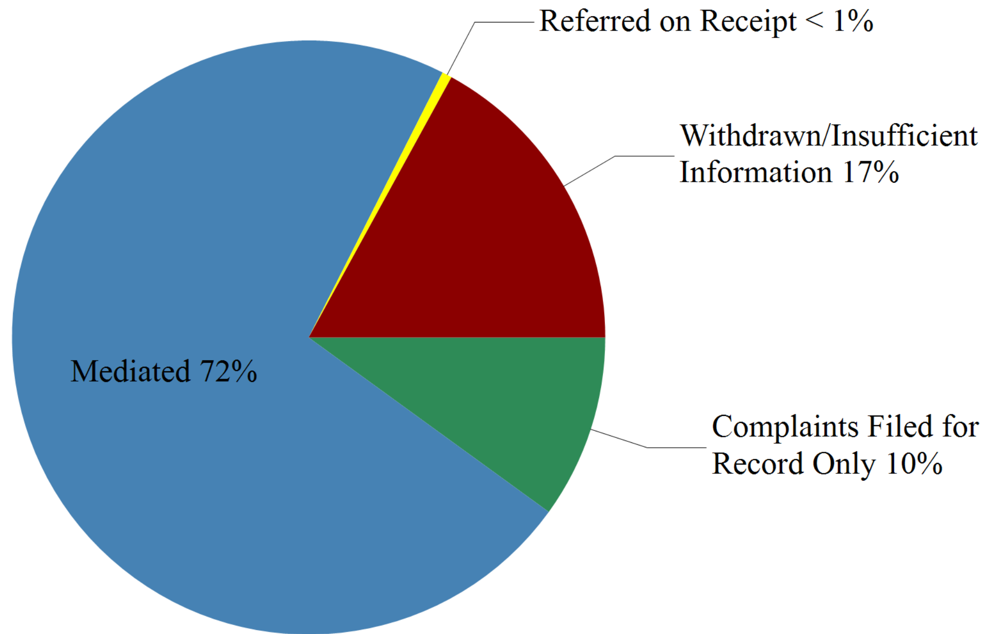
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, and various other issues encountered in the health care marketplace. In addition, the HEAU assists consumers who experience enrollment difficulties on Maryland Health Connection. The chart below illustrates the types of industries involved in the cases the HEAU closed during FY 2020. The HEAU closed 1,821 complaints. Some complaints were filed against more than one industry.



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

HEAU Appeals and Grievances Cases
Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Some consumers, or other persons, file complaints but never complete an authorization to release medical records, a form required by the HEAU to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. The chart below details the initial disposition of the 741 Appeals and Grievances cases closed by the HEAU during FY 2020.



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 2020. "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 537 cases in FY 2020. 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	5	1	20%	4	80%
Not State Regulated	30	13	43%	17	57%
Total Complaints	**35**	**14**	**40%**	**21**	**60%**
AIM Specialty Health					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
All Savers Insurance Co.					
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%**
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	14	13	93%	1	7%
Total Complaints	**14**	**13**	**93%**	**1**	**7%**
Anthem Blue Cross Blue Shield Ohio					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Anthem UM Services, 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%**
Bankers Fidelity Life Insurance Company					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Blue Cross and Blue Shield of Illinois					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Blue Cross Blue Shield of Georgia					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Blue Cross Blue Shield of Illinois					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Blue Cross Blue Shield of Massachusetts					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Blue Cross Blue Shield of Michigan					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Blue Shield of California					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
BlueCross BlueShield of Illinois					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
BlueCross BlueShield of North Carolina					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
BlueCross BlueShield of Texas					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Capital Blue Cross					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CareFirst					
State Regulated	101	37	37%	64	63%
Not State Regulated	57	22	39%	35	61%
Total Complaints	**158**	**59**	**37%**	**99**	**63%**
CareFirst Administrators					
Not State Regulated	5	5	100%	0	0%
Total Complaints	**5**	**5**	**100%**	**0**	**0%**
CareFirst the Dental Network					
State Regulated	11	5	45%	6	55%
Not State Regulated	5	1	20%	4	80%
Total Complaints	**16**	**6**	**38%**	**10**	**63%**
CIGNA					
State Regulated	6	3	50%	3	50%
Not State Regulated	35	22	63%	13	37%
Total Complaints	**41**	**25**	**61%**	**16**	**39%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Cigna Dental					
State Regulated	4	2	50%	2	50%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**5**	**3**	**60%**	**2**	**40%**
Conifer Health Solutions					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Consolidated Health Plans					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
CVS Caremark					
State Regulated	20	6	30%	14	70%
Not State Regulated	8	3	38%	5	63%
Total Complaints	**28**	**9**	**32%**	**19**	**68%**
Delta Dental					
State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Delta Dental of Virginia					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
DentaQuest LLC					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Dominion National					
State Regulated	2	0	0%	2	100%
Not State Regulated	2	1	50%	1	50%
Total Complaints	**4**	**1**	**25%**	**3**	**75%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Entrust, Inc.					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
eviCore Healthcare					
State Regulated	3	0	0%	3	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
Excellus Blue Cross Blue Shield					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Express Scripts					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
EyeMed Vision Care					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Freedom Life Insurance Company of America					
State Regulated	3	2	67%	1	33%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Golden Rule Insurance					
State Regulated	3	2	67%	1	33%
Total Complaints	**3**	**2**	**67%**	**1**	**33%**
Government Employees Health Association (GEHA)					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Guardian Life insurance Company of America					
State Regulated	4	3	75%	1	25%
Not State Regulated	2	1	50%	1	50%
Total Complaints	**6**	**4**	**67%**	**2**	**33%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Highmark					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Highmark Blue Cross Blue Shield of Delaware					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Humana Dental, Inc.					
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%**
Independence American Insurance Company					
State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Independence Blue Cross Blue Shield					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Johns Hopkins Advantage MD					
Not State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Johns Hopkins Employer Health Programs					
Not State Regulated	9	4	44%	5	56%
Total Complaints	**9**	**4**	**44%**	**5**	**56%**
Kaiser Permanente of the Mid Atlantic States					
State Regulated	61	42	69%	19	31%
Not State Regulated	4	2	50%	2	50%
Total Complaints	**65**	**44**	**68%**	**21**	**32%**

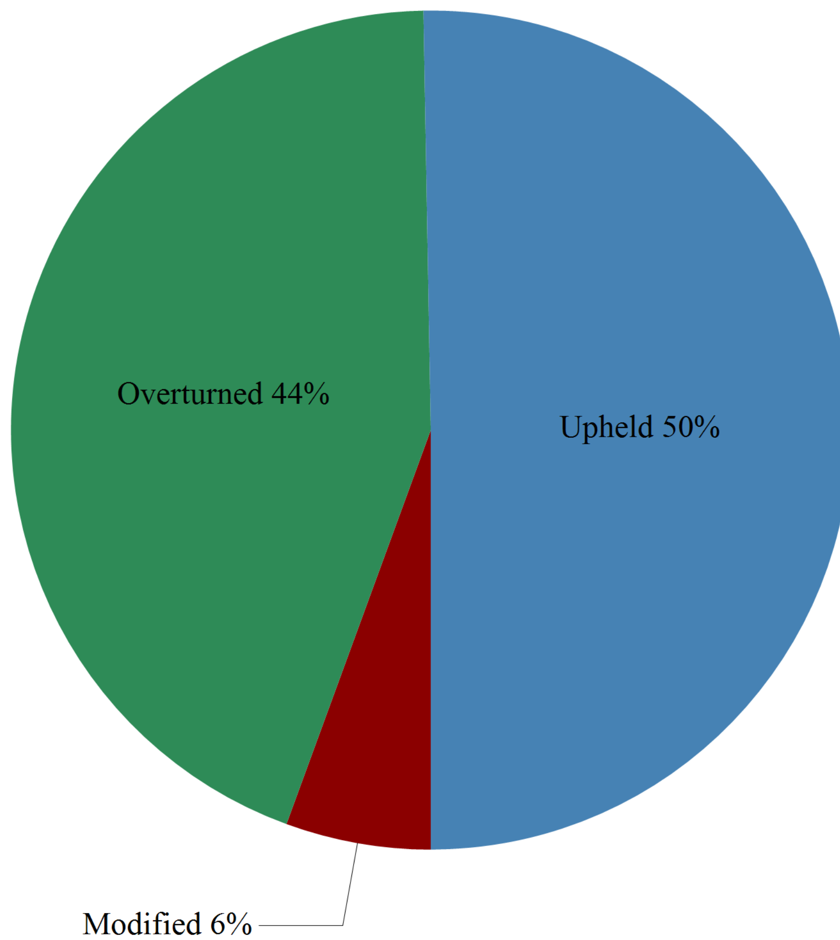
Carrier	Total Cases	Upheld		Overturned/Modified	
Magellan Rx Management					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
MAMSI Life & Health Insurance Company					
State Regulated	2	1	50%	1	50%
Total Complaints	**2**	**1**	**50%**	**1**	**50%**
Maryland Health Connection					
State Regulated	15	5	33%	10	67%
Total Complaints	**15**	**5**	**33%**	**10**	**67%**
**MDIPA	UnitedHealthcare**					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Metropolitan Life Insurance Company					
State Regulated	2	2	100%	0	0%
Not State Regulated	6	0	0%	6	100%
Total Complaints	**8**	**2**	**25%**	**6**	**75%**
National Association of Letter Carriers Health Benefit Plan					
Not State Regulated	2	2	100%	0	0%
Total Complaints	**2**	**2**	**100%**	**0**	**0%**
Optimum Choice					
State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Optum					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
OptumRx, Inc.					
State Regulated	3	2	67%	1	33%
Not State Regulated	1	1	100%	0	0%
Total Complaints	**4**	**3**	**75%**	**1**	**25%**

Carrier	Total Cases	Upheld		Overturned/Modified	
Plumbers & Pipefitters Medical Fund Benefit Account					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Premera Blue Cross Blue Shield of Alaska					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Premera Blue Cross of Washington State					
Not State Regulated	3	3	100%	0	0%
Total Complaints	**3**	**3**	**100%**	**0**	**0%**
Principal Life Insurance Company					
State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
TeamCare					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**
Teamsters Local 639 Employers Health Fund					
Not State Regulated	3	0	0%	3	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
The Loomis Company					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Tricare					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**
Truck Drivers and Helpers Local 355 Health and Welfare Fund					
Not State Regulated	1	0	0%	1	100%
Total Complaints	**1**	**0**	**0%**	**1**	**100%**

Carrier	Total Cases	Upheld		Overturned/Modified	
UMR					
Not State Regulated	4	3	75%	1	25%
Total Complaints	**4**	**3**	**75%**	**1**	**25%**
United Behavioral Health					
State Regulated	1	0	0%	1	100%
Not State Regulated	2	0	0%	2	100%
Total Complaints	**3**	**0**	**0%**	**3**	**100%**
United Concordia Insurance Company					
State Regulated	1	0	0%	1	100%
Not State Regulated	6	1	17%	5	83%
Total Complaints	**7**	**1**	**14%**	**6**	**86%**
UnitedHealthcare					
State Regulated	34	19	56%	15	44%
Not State Regulated	54	28	52%	26	48%
Total Complaints	**88**	**47**	**53%**	**41**	**47%**
US Family Health Plan - Johns Hopkins Medical Service Corp.					
Not State Regulated	2	0	0%	2	100%
Total Complaints	**2**	**0**	**0%**	**2**	**100%**
Zenith American Solutions					
Not State Regulated	1	1	100%	0	0%
Total Complaints	**1**	**1**	**100%**	**0**	**0%**

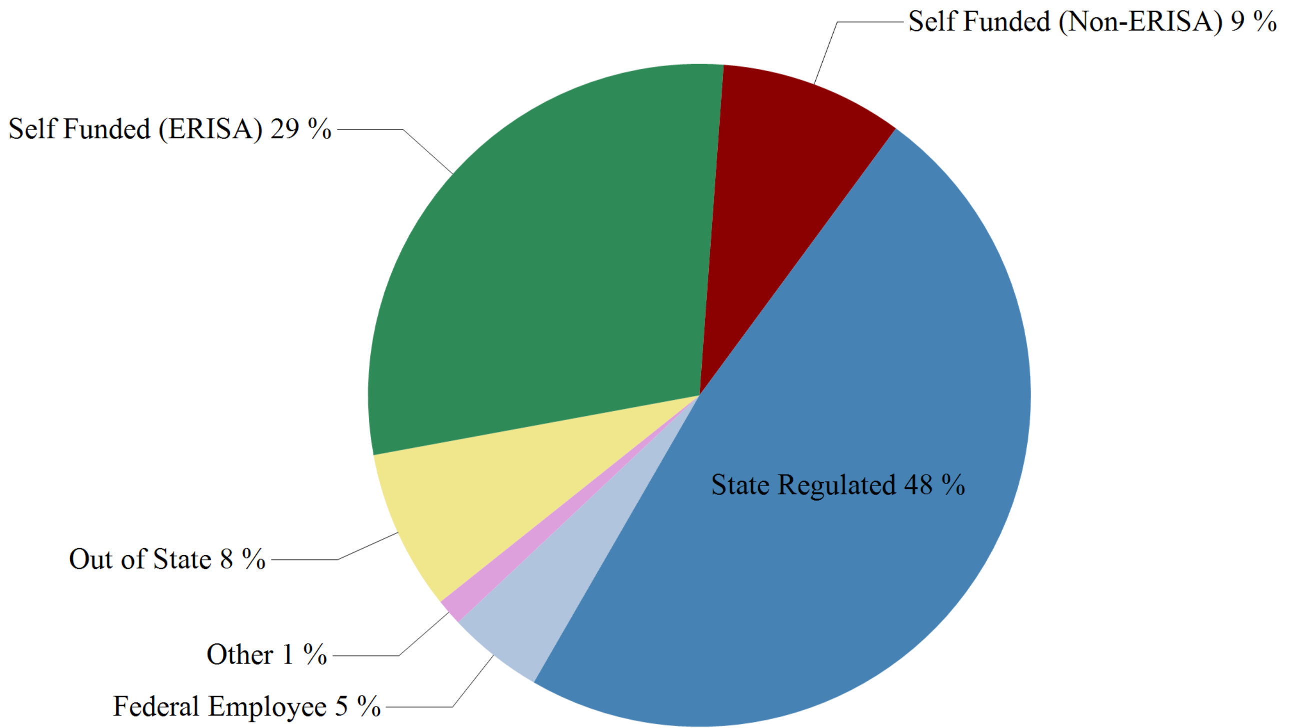
HEAU Mediated Appeals and Grievances Cases
Disposition

Carriers may uphold, overturn, or modify their decisions during the appeals and grievances process. The chart below identifies the outcomes of the Appeals and Grievances cases that the HEAU mediated and closed during FY 2020.



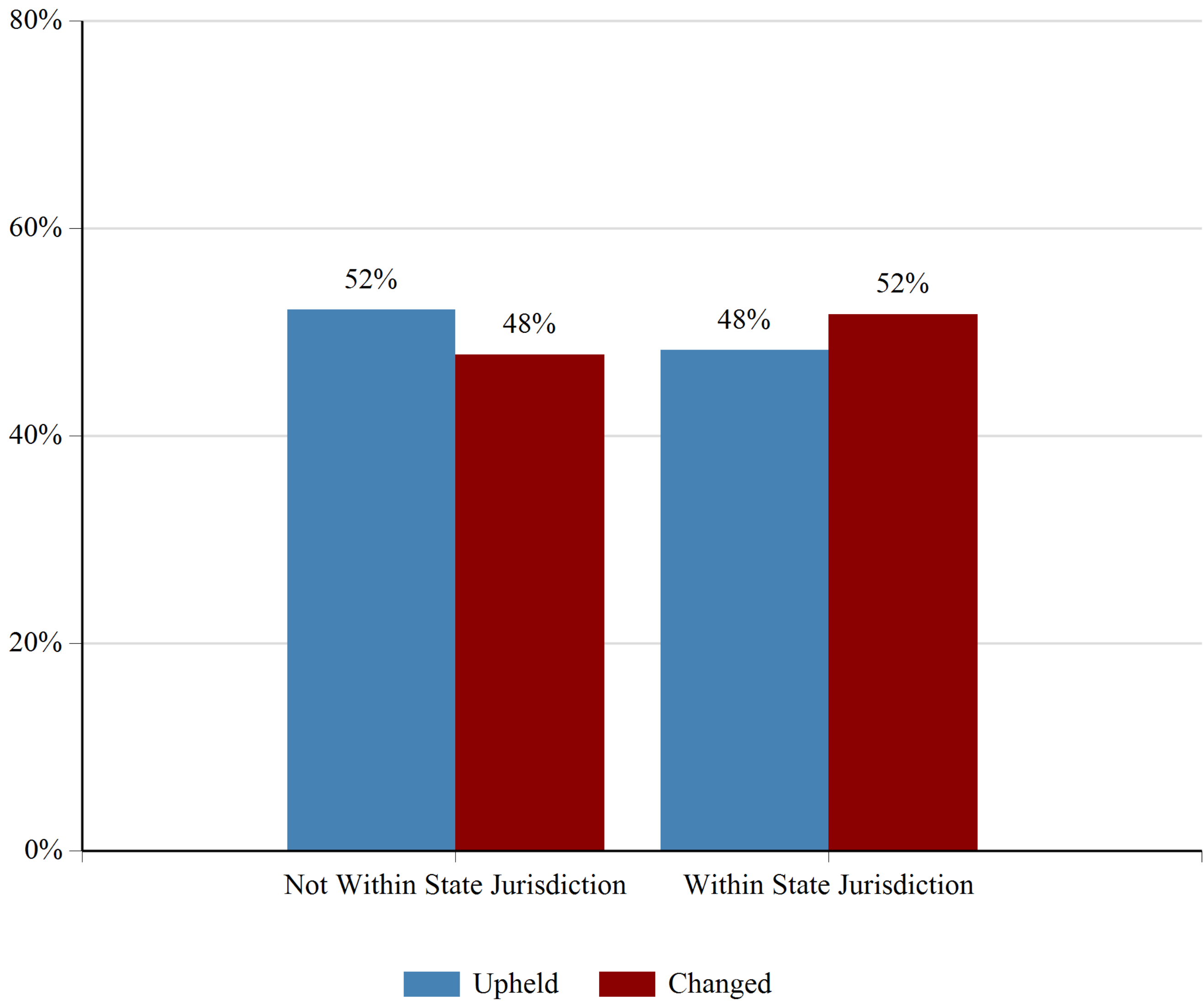
HEAU Mediated Appeals and Grievances Cases
Types of Carriers

The chart below identifies the primary carrier types involved in the 565 Appeals and Grievances cases the HEAU mediated and closed during FY 2020.



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

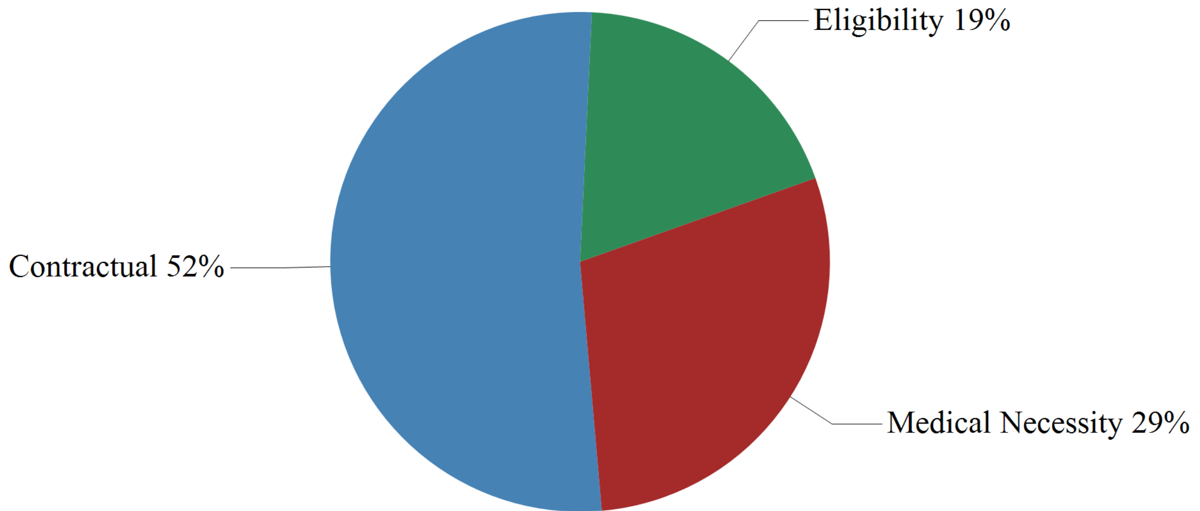
The chart below reflects the outcomes of the 537 Appeals and Grievances cases the HEAU mediated and closed during FY 2020 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

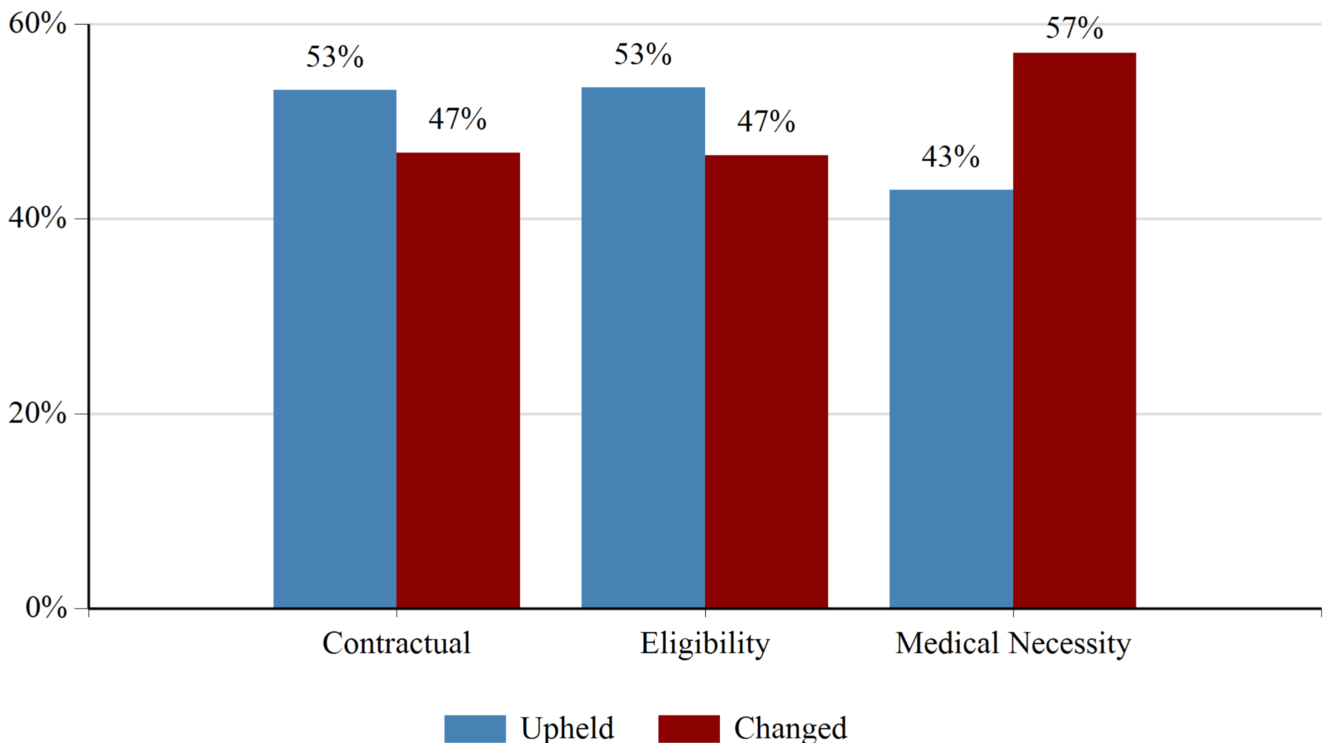
Types of Denials

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 2020.



Outcomes by Denial Type

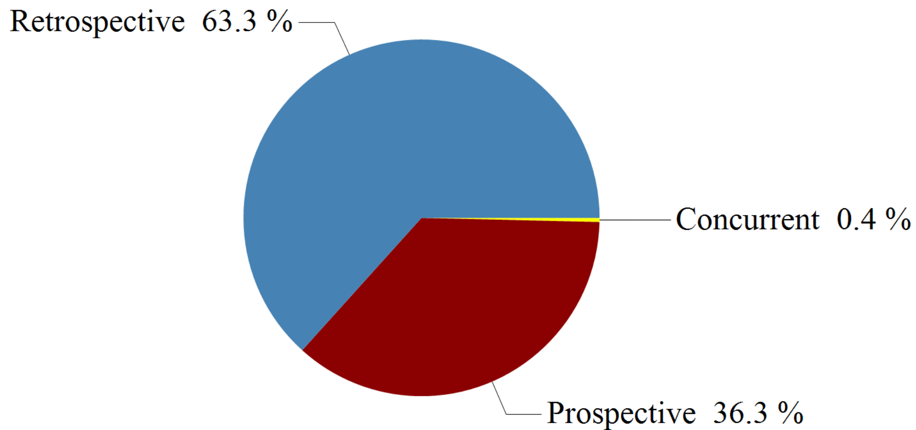
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2020.



HEAU Mediated Appeals and Grievances Cases

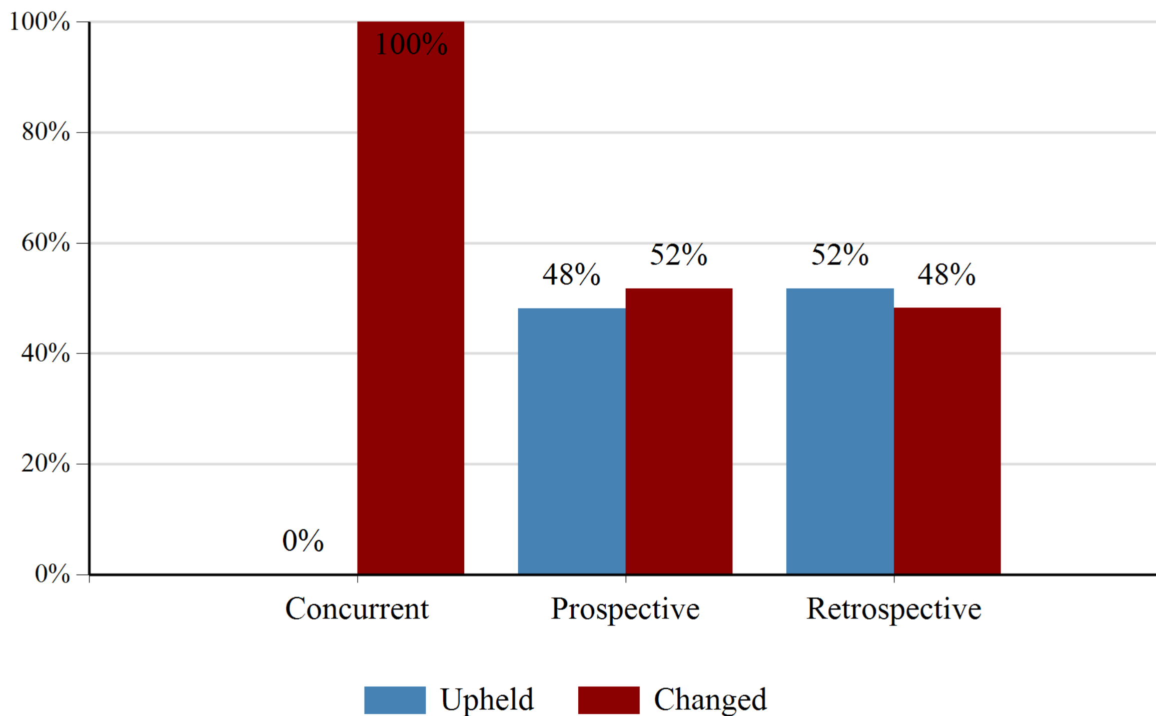
Timing of Denials

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 2020. Eligibility disputes are treated as prospective denials.



Outcomes by Timing of Denials

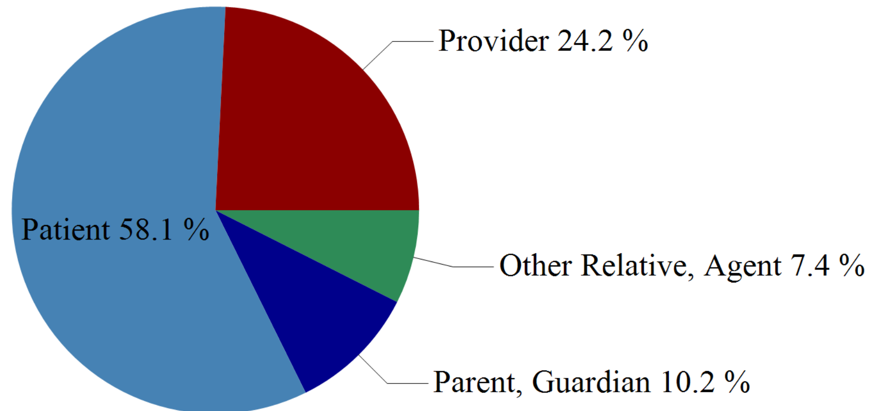
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2020 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

Who Filed the Case

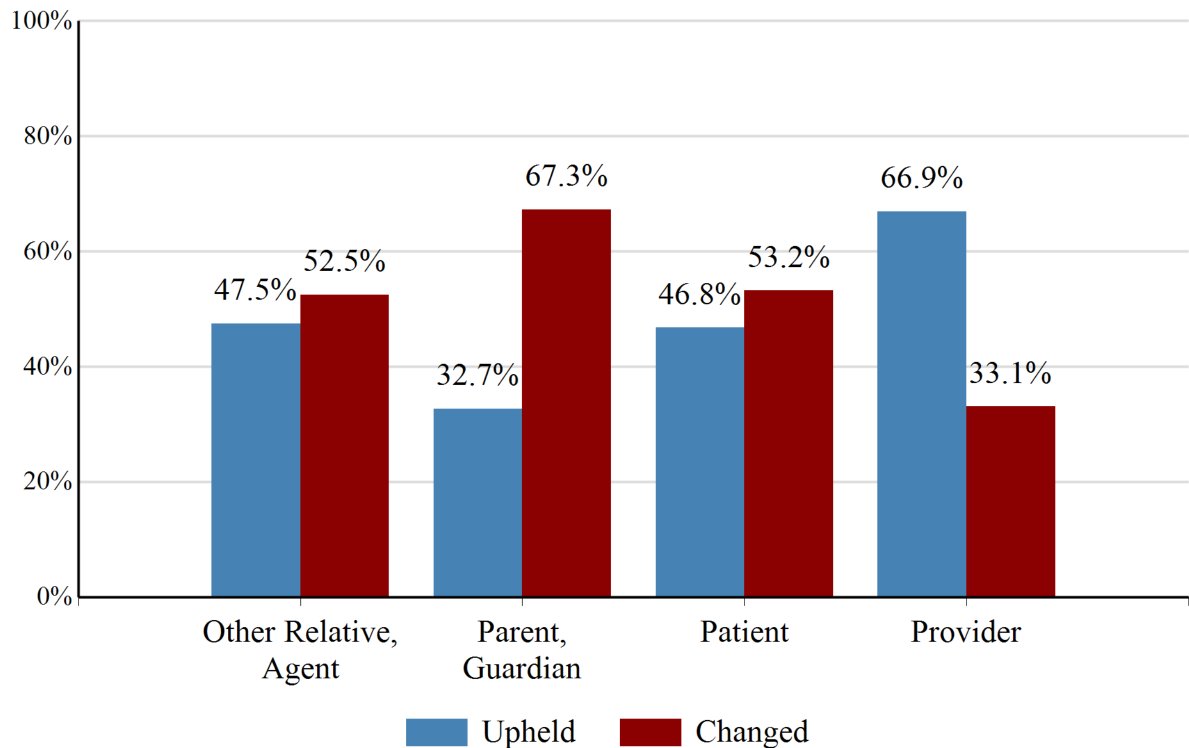
Complaints may be filed by patients or filed on behalf of patients by providers, parents, other relatives, or other agents. The chart below shows who filed Appeals and Grievances cases the HEAU mediated and closed during FY 2020.



Percentages may not equal 100% due to rounding.

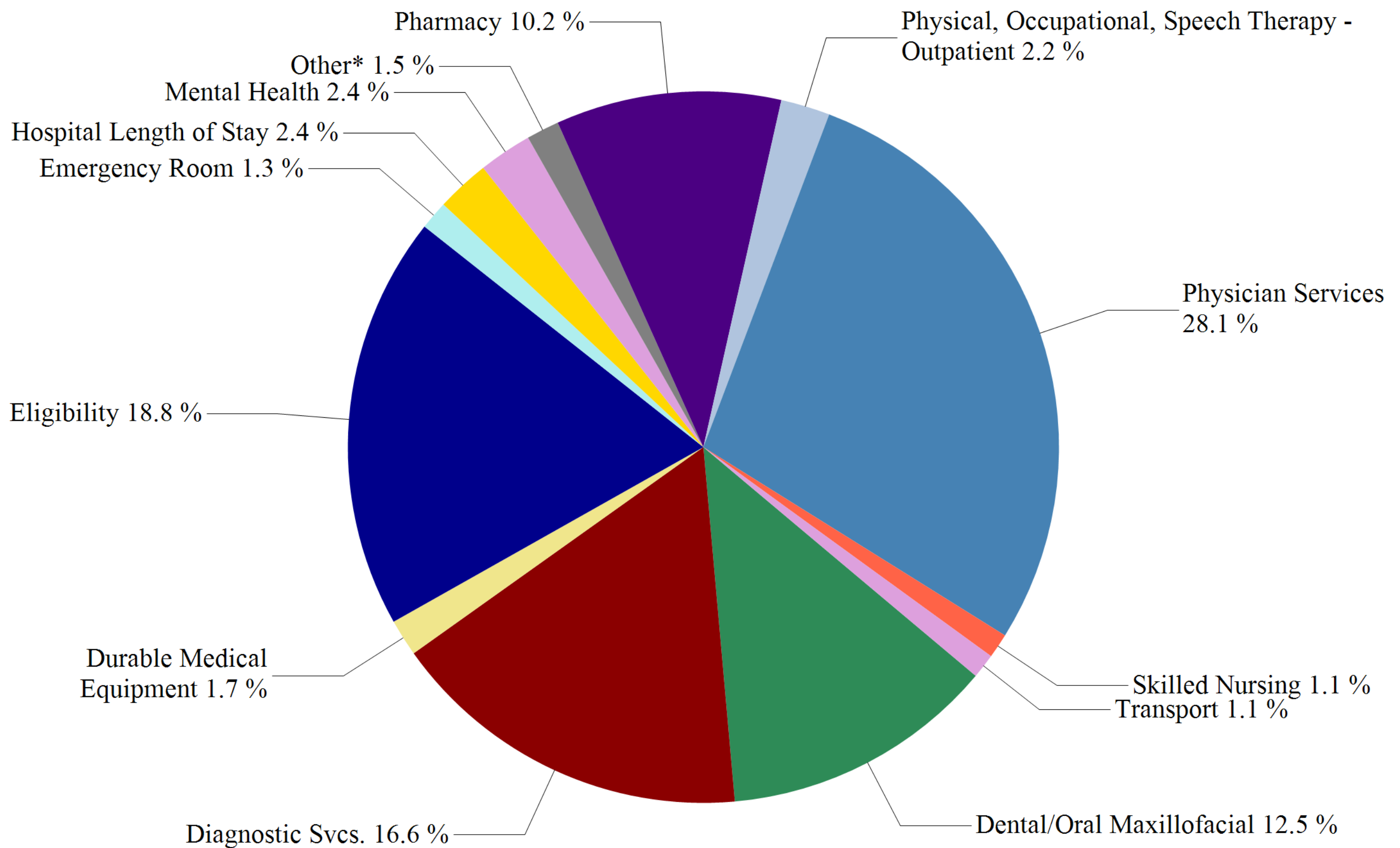
Outcomes by Who Filed the Case

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 2020.



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 2020.

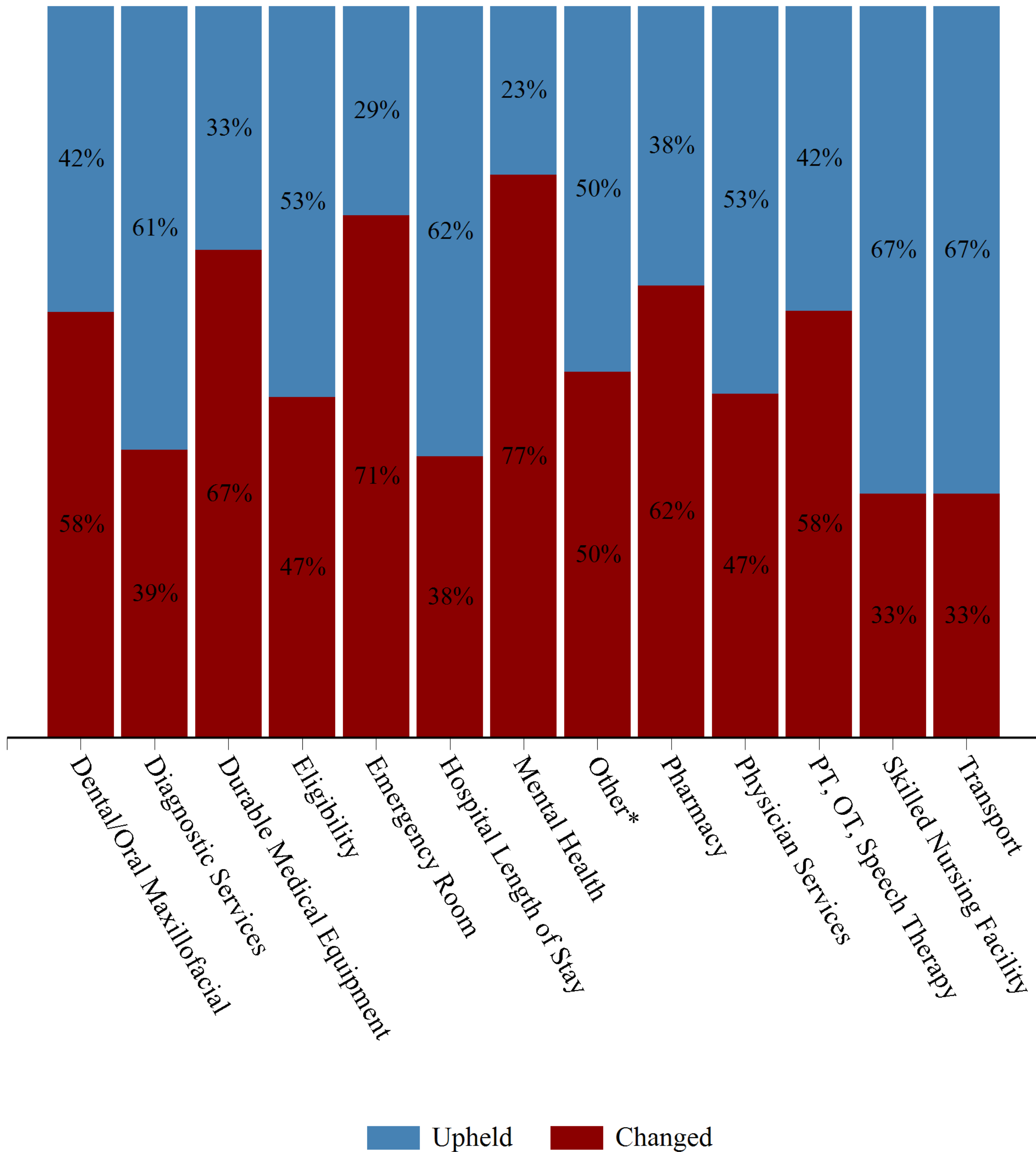


* "Other" includes acupuncture, inpatient physical rehabilitation, optometry, products and supplements, substance abuse, and other non-specific categories (e.g. nutrition therapy).

Percentages may not equal 100% due to rounding.

HEAU Mediated Appeals and Grievances Cases
Outcomes by Service Type

The chart below compares the outcomes of the Appeals and Grievances cases the HEAU mediated and closed during FY 2020 based on the types of services denied.



* "Other" includes acupuncture, inpatient physical rehabilitation, optometry, products and supplements, substance abuse, and other non-specific categories (e.g. nutrition therapy).