HB1337 (Senate)_FAV_MedChi_HI - Appeals & Grievanc
Uploaded by: Danna Kauffman
Position: FAV

MedChi

The Maryland State Medical Society

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TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Jamila J. Woods

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine K. Krone
410-244-7000

DATE: March 26, 2024

RE: **SUPPORT** – House Bill 1337 – *Health Insurance – Appeals and Grievances Process – Reporting Requirements*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports** House Bill 1337, as amended by the House of Delegates. As amended, this bill adds two elements to the quarterly reporting required by health insurance carriers for inclusion in the annual appeals and grievances report. The two items are: (1) the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by the carrier; and (2) the number of clean claims for reimbursement processed by the carrier.

This bill is a consumer protection bill to add greater transparency as to the activities of regulated insurance carriers in the State, which can help guide future policy. MedChi urges a favorable vote.

DOCS-#234821-v1-HB_1337_League_SUPPORT.pdf
Uploaded by: Matthew Celentano
Position: FAV

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

March 26, 2023

The Honorable Pam Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

House Bill 1337 – Health Insurance – Appeals and Grievances – Reporting Requirements

Dear Chair Beidle,

The League of Life and Health Insurers of Maryland, Inc. supports *House Bill 1337 – Health Insurance – Appeals and Grievances – Reporting Requirements* and urges the committee to give the bill a favorable report.

House Bill 1337 already requires carriers on a quarterly basis, to submit to the Commissioner, on the a report that describes information on the appeals and grievance process as well as data on those procedures. HB 1337 adds to this report the number of members entitled to health care benefits issued in the state as well as the number of clean claims for reimbursement processed by each carrier.

As we reform the prior authorization process this session with a variety of approaches and legislative initiatives, HB 1337 is a logical step in created transparency for consumers.

For these reasons, the League urges the committee to give House Bill 1337 a favorable report.

Very truly yours,

Matthew Celentano
Executive Director

cc: Members, Senate Finance Committee

HB1337 (2024) Senate Testimony in SUPPORT.pdf
Uploaded by: Michael Walsh
Position: FAV

Testimony in SUPPORT of HB 1337

Health Insurance - Appeals and Grievances Process-Reporting Requirements and Establishment of Workgroup

Senate Finance Committee | March 25, 2024

FAVORABLE

Dear Honorable Chair Beidle, Vice Chair Klausmeier, and Members of the Committee -

I am writing today because for too many years I have been concerned about how hard private health insurance companies are making it to get reimbursed for claims, leaving people with unplanned medical bills. It puts even more work on healthcare providers, the heroes we already ask so much of day-in and day-out, and creates even more stress for patients by asking them to manage appeals on their own, of which many of us do not have the time or resources to navigate independently.

The number of unjustified claim and care denials continues to grow each year. Here in Maryland alone we saw a 12.5% increase in adverse decisions in FY2022. In that same period we saw that only 11% of policyholders filed a grievance, but 54% of those adverse decisions were overturned or modified. That led to patients recovering over $1.7 million dollars through the appeals and grievances process, savings that are critical to working-class families struggling to survive. If that is the pattern of behavior in such a small sample of decisions, what is happening in the other 90%?! I know that If I were to receive a performance review at work and in the first 10% of my deliverables more than half of the data was wrong, I'd find myself under much more stringent review and having to provide more transparency into what I am doing.

As consumers of these insurance products, we deserve better. And to help advocate for consumers, the agencies and resources our state has created to protect us, like the Maryland Insurance Administration and the Health Education and Advocacy Unit of the Office of the Attorney General, need more transparency from these companies to ensure their practices and behaviors are legal, acting in the best interest of the people. While the state has visibility into some of these performance indicators, even basic sets of data like the total number of people covered under a policy are not reported making it difficult to understand the full picture of what coverage decisions private insurance companies are making relative to all of their policyholders.

Passing this bill will help to increase transparency that will aid regulators, policyholders, and anyone trying to choose a health insurance plan. For what we are paying, we all deserve better.

Please Support HB 1337 and encourage your Senate colleagues to do the same.

Sincerely,

Michael Walsh | walsh2.michael@gmail.com
1426 Cedarhurst Road
Shady Side, MD 20764

Testimony in support of crossover bill HB1337.pdf
Uploaded by: Richard KAP Kaplowitz
Position: FAV

CROSSOVER BILL HB1337_RichardKaplowitz_FAV
3/26/2024
Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON CROSSOVER BILL HB#/1337 – FAVORABLE
Health Insurance - Appeals and Grievances Process - Reporting Requirements and Establishment of Workgroup

TO: Chair Beidle, Vice Chair Klausmeier and members of the Finance Committee

FROM: Richard Keith Kaplowitz

My name is Richard K. Kaplowitz. I am a resident of District 3. I am submitting this testimony in support of CROSSOVER BILL HB#1337, Health Insurance - Appeals and Grievances Process - Reporting Requirements and Establishment of Workgroup

This bill is an attempt to collect data on the provision of medical care and payment for that care by insurance companies in Maryland. It will add transparency to the decision-making processes used by health care insurance companies including who is the human behind the determinations My health and the health of my wife was negatively impacted by an adverse decision by my and what are the processes for approval or denial of health care reimbursements.

I was covered by a Medicare Advantage plan carrier in 2022. I needed a total knee replacement. I wanted to stay in the hospital for a few days and then go to a local rehabilitation center for 10 days. Medicare pays for that ten day stay. My wife is mobility challenged so it would give me time to recover and minimize negative effects on her to have to take care of me. Instead, Humana Medicare Advantage wanted a total knee replacement for a 69 year old man with a 72 year old spouse to do the surgery as outpatient! My doctor was able to get only an overnight stay at hospital, my carrier would not authorize the Medicare funded rehabilitation stay. This meant weeks of pain and suffering for me and hardship for my wife.

This bill will make insurance carriers more responsive on a case-by-case basis for any decision denying care. Denial and approval statistics will be made available to the Maryland Health Commissioner to determine what the responsibilities of the carriers could have and should have been. The bill will authorize the AG to review the carrier's policies on payment for care.

This problem occurs because insurance companies are more concerned with the bottom line and shareholders than the patients who need that insurance coverage. Health care is and should always be a human right. The *Connecticut Mirror* noted in March of 2023 "How Cigna saves millions by having its doctors reject claims without reading them". [1] Despite my surgeon's appeal for my post operation care it was denied. This bill will make such a denial transparent offering additional opportunities to health care providers, patients, and government agencies the information needed to create policies to produce better decisions and outcomes for patients.

I respectfully urge this committee to return a favorable report and pass CROSSOVER BILL HB1337.

[1] https://www.newsbreak.com/news/2969704211668-how-cigna-saves-millions-by-having-its-doctors-reject-claims-without-reading-them?_f=app_share&s=a3&share_destination_id=MTM3MDgyMTEtMTY3OTgwODQ4OTA5Mg%3D%3D&pd=00vW8Bux&hl=en_US&send_time=1679808489&actBtn=floatShareButton&trans_data=%7B%22platform%22%3A1%2C%22cv%22%3A%2223.12.0%22%2C%22languages%22%3A%22en%22%7D