March 5th, 2024

Dear Honorable Chair Pena-Melnyk, Vice Chair Cullison and Members of the Health and Government Operations Committee,

People's Action writes to express our strong support for HB1337, Health Insurance-Appeals and Grievances Process-Reporting Requirements and Establishment of Workgroup Act, which would require Maryland health insurance carriers to disclose more information about how many policyholders they insure and how many claims for reimbursement are processed by the carrierer. The bill would also create a new workgroup to review whether consumers are aware of and understand the appeals and grievance processes and whether there are improvements that can be made. The work group can also examine whether carriers are currently using AI or have future plans to use AI in these processes.

Everyone should have access to the care they need, when they need it. It doesn't help people to have a health insurance plan if they can't get the care they need when and where they need it. Care denials cause medical debt, bankruptcy, worse health outcomes, and in some cases even premature death due to care not received. According to the Kaiser Family Foundation, 1 in 11 adults reported that they delayed or did not get care because of cost reasons and nearly 1 in 10 adults (23 million people) owe over $250 in medical debt.

People's Action's Care Over Cost campaign is made up of grassroots groups organizing nationwide to address the systemic problem of care denials by private insurance corporations. Everyone is affected by care denials, whether that looks like a prior authorization denial that prevents someone from getting the treatment they need or insurance's refusal to pay for treatment someone has already received via a claim denial. Insurance companies offer a process through which policyholders can appeal denials, but the processes can be confusing, opaque, and time consuming. And they are designed and managed by the private insurers themselves, who stand to profit by denying the appeal. The Care Over Cost campaign is organizing people experiencing care denials and helping them file appeals and run public pressure campaigns on the insurance corporations to overturn the denials, and elevating the peoples' stories in traditional and digital media.

Despite an increase in the percentage of people in the U.S. and in Maryland with health insurance, in recent years, the U.S. mortality rate has fallen, with an estimated drop of 5.3% in

2022 as compared to 2021.[1] The U.S. has a lower average life expectancy by six years than the average of our peer countries. Inequities in health outcomes persist across race and class. Americans in higher income brackets experience a longer life-expectancy at each age than their low-income counterparts, a gap that has widened in recent decades.[2] Denials of care and corporate profiteering is not the only reason that our healthcare system is failing but it is a major contributor.

Nationally available data indicates high rates of denials of health care claims. In 2020, nearly 1 in 5 in-network claims submitted under health insurance plans purchased through the ACA marketplace were denied.[3] In 2021, the number dropped slightly to 17% with particular insurer's rates, varying widely around this average, ranging from 2% for some plans to 49% for others.[4]

In 2021, 17% of claims submitted under health insurance plans purchased through the ACA marketplace were denied, with some plans having denial rates as high as 49%.[5] A recent report by the Department of Health and Human Services Office of the Inspector General found that in 2019 Medicaid managed care organizations ("MCOs") fully or partially denied 1 out of 8 prior authorization requests or 12.5%.[6] Twelve of the 115 MCOs in the study had prior authorization denial rates above 25%. 6% of prior authorization requests for care for people on Medicare Advantage plans were partially or fully denied. While only 11% of these denials were appealed, 82% of those appealed resulted in the full or partially overturning of the denials.[7] Data used by the DHS Office of Inspector General was obtained directly from insurers and is not publicly available.

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[1] Farida Ahmad, Jodi Ciseqski, Jiaquan Xu, and Robert Anderson, "Provisional Mortality Data - United States, 2022," Centers for Disease Control and Prevention, May 5, 2023, https://www.cdc.gov/mmwr/volumes/72/wr/mm7218a3.htm.

[2] A 2006 study showed that between 1980 and 2000, the life expectancy gap widened for those in higher income brackets than their counterparts with lower-incomes. From 1980-1982, overall life expectancy was 2.8 years longer for those in the highest-income bracket but by 1998-2000, the life expectancy difference increased to 4.5 years; see Gopal Singh and Mohammad Siahpush, "Widening socioeconomic inequalities in US life expectancy, 1980-2000," Oxford Academic International Journal of Epidemiology, May 9, 2006, https://academic.oup.com/ije/article/35/4/969/686385.

[3]https://www.kff.org/private-insurance/press-release/marketplace-insurers-denied-nearly-1-in-5-in-network-claims-in-2020-though-its-often-not-clear-why/

[4] ACA Marketplace 48.3 million in 2020 in-network claim denials (source: https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/) . Dept of Labor est. 200 million for employer delivered health insurance in 2017.

[5] Karen Pollitz et al. "Claims Denials and Appeals in ACA Marketplace Plans in 2021," KFF, Feb. 9, 2023, https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/.

[6] Christi A. Grimm, "High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care," Department of Health and Human Services Office of the Inspector General, July 2023, https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.

[7]Jeannie Fuglesten Biniek and Nolan Sroczynski, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021," KFF, February 2, 2023, https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/.

Despite the authority to do so, the federal government does not collect and publish uniform and comprehensive data on insurance claims denials by claim type and demographics across types of insurance plans. State level data varies by state. There is little to no data available by race, ethnicity, gender or age at the state or federal level. Publishing claims and prior authorization data by race and ethnicity is particularly urgent given then we know that there are serious racial and ethnic disparities in health and health care in the United States.

ProPublica has reported that some private insurers, like Cigna Health, knowingly auto-deny claims strictly to increase their profits.[8] Private health insurance companies make the majority of their profits off of public health insurance plans, padding their pockets with taxpayer dollars.[9] Public funds are diverted from their core purpose to the profits and paychecks of health insurance executives and shareholders. For example, just three Managed Care Organizations made over $282 million in *increased* profits in the last 9 months of 2020 from Illinois Medicaid. One of those companies, Molina Healthcare, denied over 41% of claims in 2019 for their portion of the Illinois Medicaid program.[10] These profits are beyond the management fees these companies send to their parent corporations and represent a shift in public funds from poor people who need healthcare to wealthy executives and shareholders.

Over the past year, the Care Over Cost campaign helped fight and win claims denial cases throughout the country. The examples below illustrate the problem and severity of claims denials.

- A subsidiary of Elevance Health denied People's Action/Iowa Citizens for Community Improvement member Bri Moss a new insulin pump, forcing her into a stay in an emergency room. The New York Times included her story in an article on the Inspector General report on privatized Medicaid (Managed Care) claims denials noted above. After Bri's hospital stay, Care Over Cost helped her appeal and got her a new insulin pump. Elevance Health (the former Anthem BCBS) reported $8.5 billion in profits in 2022, while buying back $2.3 billion in shares.[11]

- United Healthcare denied Carly Morton life-saving surgery that would allow her to eat again. Care Over Cost waged a public campaign and with assistance from Senator Bob Casey, we won Carly's care and she had her surgery in late July 2023.[12] Carly is on a

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[8] https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims
[9] The nation's five biggest insurers have almost 60 percent of their combined revenues coming from plans funded by Medicare and Medicaid. https://www.cnbc.com/2017/12/04/most-of-top-insurers-revenue-comes-from-medicare-medicaid.html
[10] https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf
[11] Elevance Health Press Release, "Elevance Health Reports Fourth Quarter and Full Year 2022 Results," Jan 25, 2023, https://www.elevancehealth.com/newsroom/elv-quarterly-earnings-q4-2022.
[12] Video of Carly Morton, People's Action, March 29, 2023, https://twitter.com/PplsAction/status/1641136092081422340.

Medicare Advantage (privatized Medicare) plan. UnitedHealth Group reported $20.1 Billion in profits in 2022 alone.[13]

- After two rounds of cancer treatment, side effects from a mastectomy and breast reconstruction surgery put former State Representative (R-NH) and emergency medical technician Jenn Coffey in bed for years. United Healthcare refused to pay for her treatments, forcing Jenn to sell her car and fundraise to pay for treatments. Care Over Cost campaigned to win Jenn approval for her first round of treatment, but Jenn is now navigating repeated prior-authorization processes that hinder her care. Care Over Cost and New Hampshire Senators Shaheen and Hassan continue to work with Jenn to help remove these and other obstacles to her life-saving care.[14] United Health Group is the largest provider of Medicare Advantage plans (27.1% market share) and is accused of fraud and overbilling by the federal government.[15]

In conclusion, increasing transparency in reporting from insurers including about claims and prior authorization denials is a crucial first step in reigning in the growing problem of delays and denials of care in Maryland and across the country. Thank you for the opportunity to testify in support of HB1337.

Sincerely,

Megan Essaheb
Director of Federal Affairs
People's Action

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[13] Bruce Japsen, "UnitedHealth Group Reports $4.7 Billion Profit As Optum And Health Plans Maintain Momentum," Jan. 13, 2023, https://www.forbes.com/sites/brucejapsen/2023/01/13/unitedhealth-group-reports-47-billion-profit-as-optum-and-health-plans-maintain-momentum/?sh=1edf29776837.
[14] Video of Jenn Coffey, People's Action, April 14, 2023, https://twitter.com/PplsAction/status/1646880876943355904.
[15] Reed Abelson and Margot Sanger-Katz, "'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions," New York Times, Oct. 8, 2022, https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html.