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February 26, 2025

TO: The Honorable, Pamela Beidle, Chair
Senate Finance Operations Committee

FROM: Irnise F. Williams, Deputy Director, Health Education and Advocacy Unit

RE: Senate Bill 0776- Workgroup to Study the Rise in Adverse Decisions in the State Health Care System – Establishment- **SUPPORT**

The Health Education and Advocacy Unit (HEAU) supports Senate Bill 776, which should help regulators assess compliance with appeals and grievance laws, identify trends and areas that warrant critical review and compliance action, and ensure that enrollees are not denied access to medically necessary care.

As the Committee is likely aware, there has been a great deal of reporting recently highlighting the impact of carrier denials on consumers' access to care, health, and financial stability. A 2023 KFF Survey of Consumer Experiences with Health Insurance found that "58% of insured adults said they have experienced a problem using their health insurance, including denied claims. Four in ten (39%) of those who reported having trouble paying medical bills said that denied claims contributed to their problem." Another recent KFF Report found that "Insurers of qualified health plans (QHPs) sold on HealthCare.gov denied 19% of in-network claims in 2023 and 37% of out-of-network claims for a combined average of 20% of all claims." The in-network denial ranged from 1% to 54%. The same report found that consumers rarely file an internal grievance with the carrier (fewer than 1% of denied claims were challenged) and when they do, insurers usually uphold their original decision (56% of challenges were upheld).

That data is consistent with the data the HEAU has reported year-over-year in Annual Reports. Based on carrier reported data over the last ten fiscal years, only 10% of adverse decisions were challenged, and on average, 54% of those grievances were reversed when challenged. The HEAU has assisted many Marylanders whose claims have been denied. In the HEAU's most recent Annual Report to the General Assembly, HEAU highlighted several consumer stories that demonstrate the gravity of adverse decisions on a consumer's health and access to care:

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

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

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

These examples demonstrate the value of HEAU's assistance when consumers obtain it, but such assistance is a back-end solution to the problem. Health claim denials, particularly when unwarranted, harm consumers by delaying necessary care, risking consumer health and the financial stability of their households. These concerns deserve front-end solutions and warrant critical review by the regulators.

In the last few years, the General Assembly has worked to increase transparency in denial trends, but this workgroup will provide a global review of reporting elements and make fully informed holistic recommendations to ensure regulators have the necessary data needed to warrant critical review and compliance action and ensure that enrollees are not denied access to medically necessary care.

We urge a favorable report and thank the Chair for her amendment adding the HEAU to the workgroup.