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February 10, 2025

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

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

RE: Senate Bill 0474- Health Insurance - Adverse Decisions – Reporting and Examinations- **SUPPORT**

The Health Education and Advocacy Unit (HEAU) supports Senate Bill 474, and the opportunity for increased transparency in required data submitted by carriers to the Maryland Insurance Administration (MIA). This bill requires carriers to highlight specific adverse decision data, and an explanation for the increase. This report will identify potential issues with the carriers' decision-making process, which should warrant critical review by the MIA.

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, which in turn harms their 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." A recent Pro Publica investigation sheds light on how carriers' utilization review programs are tailored to deny as much patient care as possible, in part by:

a) overruling doctors' requests as often as possible and maximizing denial rates for patient care;
b) using guidelines for approving or denying care that are often inconsistent with the recommendations of medical professionals;
c) setting its fax machines to receive only 5 to 10 pages so that it could deny requests longer than the limit for failing to have enough documentation; and
d) using an algorithm backed by artificial intelligence, which some insiders call 'the dial,' that it can adjust to lead to higher denials.

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 the patient. 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.

The impact of adverse claims causes delays in care and harms consumers physically, mentally, and financially. In the last few years, the General Assembly has continuously worked to increase transparency in denial trends, and this would be another step toward understanding the variability of adverse decisions.

This bill also refers to the Commissioner's power established in Insurance Article § 2-206 to use the data that is being reported as the basis for a market conduct examination. Though we believe this provision is unnecessary because the Commissioner has long held the authority to conduct such an examination "when advisable to determine compliance" with the Insurance Article, the HEAU doesn't object to the specific enumeration in this bill of the Commissioner's already existing authority.

We urge a favorable report.

cc: The Honorable Pamela Beidle