LCPCM-SB474 - Health Insurance- Adverse Decisions-
Uploaded by: Andrea Mansfield
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee:	Senate Finance Committee
Bill:	SB 474 – Health Insurance – Adverse Decisions – Reporting and Examinations
Hearing Date:	February 12, 2025
Position:	Support

The Licensed Clinical Professional Counselors of Maryland (LCPCM) support SB 474 – Health Insurance – Adverse Decisions – Reporting and Examinations. This bill requires health insurers to report to the Maryland Insurance Commissioner the number of adverse decisions by type of service if they have grown by a certain percentage.

Insurance carriers are already required to report to the Maryland Insurance Commissioner on a quarterly basis regarding the appeals and grievances of specific activities. SB 474 expands the activities reported to include adverse decisions for a type of service that has grown by more than 10% in the immediately preceding calendar year or 25% in the immediately preceding three years.

As licensed clinical professional counselors, we want to ensure our clients have access to services and they are affordable. Situations may occur where insurance companies deny coverage for clients for various reasons. Without regular monitoring of these decisions to deny coverage, we would not know if denials are justified or related to a gap in coverage.

Adverse decision data will help identify coverage gaps and enable insurance companies to address them to improve access and effect better patient outcomes. For these reasons LCPCM urges the Committee to give SB 474 a FAVORABLE Report.

Please contact Andrea Mansfield at amansfield@maniscanning.com or (410)562-1617 if we can provide additional information.

SB0474_Health_Insurance_Adverse_Decisions_MLC_FAV.
Uploaded by: Cecilia Plante
Position: FAV

MARYLAND LEGISLATIVE COALITION

TESTIMONY FOR SB0474
Health Insurance – Adverse Decisions – Reporting and Examinations

Bill Sponsor: Senator Beidle
Committee: Finance
Organization Submitting: Maryland Legislative Coalition
Person Submitting: Cecilia Plante, co-chair
Position: FAVORABLE

I am submitting this testimony in strong support of SB0474 on behalf of the Maryland Legislative Coalition. The Maryland Legislative Coalition is an association of activists - individuals and grassroots groups in every district in the state. We are unpaid citizen lobbyists and our Coalition supports well over 30,000 members.

In this country, we don't have a health care system. We have a system of health care providers who are in the business to make money. They care little for the health of the people who are enrolled in their business and often will deny coverage for important procedures, drugs, or physician visits with little transparency.

At the very least, we should all understand which insurance carriers deny coverage more frequently. This bill, if enacted, would require insurance carriers to report to the Maryland Insurance Commissioner on a quarterly basis the number of adverse decisions for a type of service that has grown by more than 10% in the immediately preceding calendar year, or 25% in the immediately preceding three calendar years and any reasons for the increase.

This will allow the Commissioner to understand where the carriers are trying to make excess profits.

We strongly support this bill and recommend a **FAVORABLE** report in committee.

SB0474 - Health Insurance - Adverse Decisions - Re

Uploaded by: Charlotte Hoffman

Position: FAV

Charlotte Persephone Hoffman, Esq.
(they/she)
Policy Director
charlotte@transmaryland.org

Monday February 10, 2025

The Honorable Pamela Beidle
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Testimony of Trans Maryland

IN SUPPORT OF

SENATE Bill #474: Health Insurance - Adverse Decisions - Reporting and Examinations

To the Chair, Vice Chair, and esteemed members of the Senate Finance Committee:

Trans Maryland is a multi-racial, multi-gender community power-building organization for Maryland's trans community. Trans Maryland believes in protecting the rights of all Marylanders, particularly transgender community members, to access safe, inclusive, and appropriate healthcare, and that such healthcare should not be denied for arbitrary reasons.

Unfortunately, living with insurance coverage denials is part of life for many transgender Marylanders. Indeed, studies demonstrate that transgender individuals are much more likely to be denied care than their cisgender counterparts.[1] Despite formal plan coverage or pharmaceutical formularies, too many of us find our care unexpectedly denied, even when we have been receiving the same care from the same doctors, paid for by the same insurance providers, for months or years.

Recently, I found my own prescription for estradiol patches—medicine used primarily by cisgender women going through menopause—inexplicably rejected by my own insurance provider after years of coverage, presumably for no reason other than because they hoped that I would not contest the denial and the insurance company might save a tiny amount of money. With my estradiol levels suddenly plummeting, I experienced many of the symptoms of menopause, including hot flashes, headaches, muscle aches, and fatigue—all because an insurance company decided it didn't want to pay for a prescription it had been paying for for years.

---

[1] Shanna K. Kattari, Matthew Bakko, Hillary K. Hecht, M. Killian Kinney,
Intersecting Experiences of Healthcare Denials Among Transgender and Nonbinary Patients,
American Journal of Preventive Medicine,
Volume 58, Issue 4,
2020, https://www.sciencedirect.com/science/article/pii/S0749379719305380

TRANS MARYLAND

Charlotte Persephone Hoffman, Esq.
(they/she)
Policy Director
charlotte@transmaryland.org

My story is not unique, and the fact that it happened with such a routine medication—again, one primarily prescribed to cisgender women for menopause—demonstrates that this is not simply a transgender issue, but rather an issue all Marylanders are facing together.

While Senate Bill 474 will not fully address situations like this, it takes the critical first step of ensuring that data about these refusals is collected in the first place. By requiring insurance companies to report increases in denial rates over time, Maryland will be able to track these trends as they happen, enabling it to act when necessary. This reporting will also discourage insurers from adopting arbitrary denials as a cost-cutting measure, as they will eventually have to report—and explain—those denials to the state.

For these reasons, Trans Maryland urges a favorable report on Senate Bill #474.

SB0474_FAV_MedChi, MDAFP, MDACEP, MDAAP, MDACOG, M
Uploaded by: Danna Kauffman
Position: FAV

Senate Finance Committee
February 12, 2025
Senate Bill 474 – *Health Insurance – Adverse Decisions – Reporting and Examinations*
POSITION: SUPPORT

On behalf of MedChi, The Maryland State Medical Society, the Maryland Academy of Family Physicians, the Maryland Chapter of the American College of Emergency Physicians, the Maryland Chapter of the American Academy of Pediatrics, the Maryland Section of The American College of Obstetricians and Gynecologists, the Mid-Atlantic Association of Community Health Centers, and the Greater Washington Society for Clinical Social Work, we submit this letter of support for Senate Bill 474.

Senate Bill 474 seeks to provide greater oversight and enforcement related to the number of denials issued by healthcare carriers. The bill states that if the number of adverse decisions by a carrier for a specific service has increased by more than 10% in the past year or 25% in the past three years, the carrier must include the following in their required report to the Maryland Insurance Administration (MIA) a description of any changes in medical management that contributed to the rise in adverse decisions and any other known reasons for the increase.

Healthcare costs and premiums continue to increase. Having insurance is not the same as being able to access health care services. There has been an alarming trend of an increase in denials. According to the latest Appeals and Grievances Report by the MIA, carriers rendered 109,123 adverse decisions in 2023 compared to 74,361 in 2020, representing an increase of 46.7% over the four-year period. Pharmacy services accounted for the highest number of adverse decisions between 2020 and 2023. Adverse decisions for pharmacy services increased by 72.2% from 2020 to 2023, (36,132 in 2020 to 62,210 in 2023). In those rare cases where a physician and/or a patient has the time to submit a complaint to the MIA, almost 70% of the time, the case is resolved (or the carrier reverses) in favor of the patient.

Hopefully, this bill, among others being considered this Session, will help stem the increase in denials and inform health insurance carriers that denial rates will be more closely examined. Under Senate Bill 474, the MIA can use the information as a trigger for an investigation, leading to greater enforcement action. For these reasons, we request a favorable report.

For more information call:
Danna L. Kauffman
J. Steven Wise
Andrew G. Vetter
Christine K. Krone
410-244-7000

SB474 Adverse Decisions LOS Final.pdf
Uploaded by: Irnise Williams
Position: FAV

CAROLYN A. QUATTROCKI
Chief Deputy Attorney General

LEONARD J. HOWIE III
Deputy Attorney General

CARRIE J. WILLIAMS
Deputy Attorney General

ZENITA WICKHAM HURLEY
Chief, Equity, Policy, and Engagement

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION
HEALTH EDUCATION AND ADVOCACY UNIT

WILLIAM D. GRUHN
Division Chief

PETER V. BERNS
General Counsel

CHRISTIAN E. BARRERA
Chief Operating Officer

IRNISE F. WILLIAMS
Assistant Attorney General

ANTHONY G. BROWN
Attorney General

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

SB 474 Health Insurance - Adverse Decisions - Repo

Uploaded by: Jake Whitaker

Position: FAV

Maryland
Hospital Association

Senate Bill 474- Health Insurance - Adverse Decisions - Reporting and Examinations

Position: *Support*
February 12, 2025
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in strong support of Senate Bill 474. SB 474 addresses the recent increase in adverse decisions by mandating that carriers report to the Maryland Insurance Administration (MIA) the reasons for any rise in adverse decisions if the number has increased by more than 10% in the previous calendar year or by 25% over the past three calendar years. This bill would also grant the Maryland Insurance Commissioner additional authority to examine and investigate significant rises in adverse decisions.

Maryland hospitals and health systems strongly support policies designed to address the recent increase in adverse decisions made by health insurers. Since 2013, the total dollar amount of claims denials for hospital services has increased threefold from $143 million to $477 million in 2024. What's more, the vast majority of adverse decisions appealed to MIA were overturned. According to the fiscal year 2023 Office of the Attorney General Annual Report on the Health Insurance Carrier and Grievances Process, 69% of carrier grievance decisions were modified or overturned. Driven in part by the use of artificial intelligence in coverage decisions, the rise in erroneous adverse decisions has only accelerated in recent years.

Unnecessary and unfair adverse decisions significantly impact health outcomes and timely access to care. When more claims are denied, patients face delays in receiving necessary treatments or may be forced to pay out-of-pocket for services that should be covered. Additionally, hospitals must divert valuable staff time and clinical resources to fight claims denials and navigate overly onerous prior authorization requirements. Denied and delayed payments also contribute to additional financial pressures and operational uncertainty that negatively impact hospitals' ability to provide care.

Maryland hospitals and health systems remain committed to supporting and creating sustainable solutions for access to affordable, comprehensive health insurance coverage. SB 474 would enhance transparency and accountability in insurance practices and coverage decisions. This legislation will promote more equitable and consistent decision-making by payers, reducing the likelihood of unfair adverse decisions by health insurers.

For these reasons, we request a favorable report on SB 474.

For more information, please contact:

Jake Whitaker, Assistant Vice President, Government Affairs & Policy
Jwhitaker@mhaonline.org

APTA MD 2025 Testimony - Support - Senate Bill 474

Uploaded by: JD Sheppard

Position: FAV

APTA Maryland

Our Vision
Transforming the diverse communities in Maryland to advance health and wellness by optimizing movement and function across the lifespan.

February 12, 2025

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

RE: Senate Bill 474 - Health Insurance - Adverse Decisions - Reporting and Examinations
Position: SUPPORT

Dear Chair Beidle,

The American Physical Therapy Association Maryland is writing to register our strong support of **Senate Bill 474**. This bill will require *"certain carriers, if the number of adverse decisions issued by carrier for a type of service has grown by more than 10% in the immediately preceding calendar year or 25% in the immediately preceding 3 calendar years, to provide certain information to the Maryland Insurance Commissioner; and authorizing the Commissioner to use certain adverse decision information as the basis of a certain examination."*

The 2021 Report on the Health Care Appeals and Grievances Law (released December 1, 2022) reports that carriers rendered 81,143 adverse decisions (e.g., denials of health care services based on the carrier's decision that the health care service was not medically necessary rather than the judgment of the treating practitioner).

In 2022, the Maryland Insurance Administration (MIA) modified or reversed the carrier's decision (or the carrier reversed it during the course of investigation), 72.4% of the time on filed complaints, up from 70.5% in 2021. This means that in more than 7 out of 10 cases, the MIA ruled that the carrier was wrong, and that the patient should have received the health care service.

The 2021 American Medical Association conducted a survey on the impact that prior authorizations have on physicians and patients and found that:

- 93% of the time physicians reported delays in access to necessary care.
- 82% of the time physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials.
- 73% of the time physicians reported that criteria used by carriers for determining medical necessity is questionable - 30% of the time physicians reported that it is rarely or never evidence-based and 43% only sometimes evidence-based.

APTA Maryland Ph. 800.306.5596 Fax 877.622.0960 aptamd@aptamd.org

APTA Maryland
A Chapter of the American Physical Therapy Association

The Data –Ultimate Outcome of Physical Therapy Denied Claims

- *13.08% of filed physical therapy claims are denied*
- *66.14% of denied physical therapy claims are appealed*
- *52.34% of appealed physical therapy claim denials are overturned*

The American Physical Therapy Association (APTA) conducted a survey on administrative burden from Dec 2018-Jan 2019. APTA members report that medically necessary physical therapist services are delayed — ultimately impacting patients' clinical outcomes — because of the amount of time and resources they must spend on documentation and administrative tasks. The volume of these tasks also leads to dissatisfaction and burnout. APTA urges policymakers and third-party payers to advance policies that streamline documentation requirements, standardize prior authorization and payer coverage policies, and eliminate unnecessary regulations.

- 85.2% of providers agree or strongly agree that administrative burden contributes to burnout.
- 74% of respondents agreed or strongly agreed that prior authorization requirements negatively impact patients' clinical outcomes.
- 76% of facilities and private practice owners have added nonclinical staff to accommodate administrative burden.
- 65% of respondents say more than 30 minutes of staff time is spent preparing an appeal for one claim.

For the reasons noted above we ask for a favorable report on Senate Bill 474.

Sincerely,

Roy Film

Roy Film, PT, DPT, MPT
President, APTA Maryland

2025 MOTA SB 474 Senate Side.pdf
Uploaded by: Jennifer Navabi
Position: FAV

Maryland Occupational Therapy Association

PO Box 36401, Towson, Maryland 21286 ♦ mota-members.com

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 474**

Title: **Health Insurance - Adverse Decisions - Reporting and Examinations**

Hearing Date: **February 12, 2025**

Position: **Support**

The Maryland Occupational Therapy Association (MOTA) supports *Senate Bill 474 – Preserve Telehealth Access Act of 2025*. *House Bill 848 - Health Insurance - Adverse Decisions - Reporting and Examinations*. This bill requires a carrier to submit a justification to the Insurance Commissioner if it experiences a rise in adverse decisions that equals more than 10% in the immediately preceding calendar year or 25% in the immediately preceding 3 calendar years.

According to data from a joint report of the Maryland Health Care Commission and Maryland Insurance Administration, adverse decisions in Maryland increased around seven percent from 2019 to 2022.[i] An adverse decision occurs when an insurance company denies a request for coverage or takes another action against a policyholder like increasing rates or terminating a policy. Without health insurance coverage, medical costs can increase exponentially, putting people into extreme debt that can lead to credit score damage, debt collection, lawsuits, garnishments, late fees and interest, bankruptcy, and delayed care. This increase in adverse decisions is concerning and prevents people from receiving appropriate and timely care. This bill well help explain the trend and can begin the process of reimagining health insurance in a way that benefits everyone.

We ask for a favorable report. If we can provide any further information, please contact Michael Paddy at mpaddy@policypartners.net.

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[i] Health Insurance – Utilization Review Revisions, An Environmental Scan of the Prior Authorization Process, November 21, 2024, https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/Health-Insurance-Utilization-Review-Revisions.pdf.

SB 474 - MIA - Support.pdf
Uploaded by: Marie Grant
Position: FAV

WES MOORE
Governor

ARUNA MILLER
Lt. Governor

MARIE GRANT
Acting Commissioner

JOY Y. HATCHETTE
Deputy Commissioner

MARY KWEI
Associate Commissioner
Market Regulation and Professional Licensing

Maryland
INSURANCE ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2113
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www.insurance.maryland.gov

Date: **February 12, 2025**

Bill # / Title: **Senate Bill 474 - Health Insurance - Adverse Decisions - Reporting and Examinations**

Committee: **Senate Finance Committee**

Position: **Support**

The Maryland Insurance Administration (MIA) appreciates the opportunity to share its support for Senate Bill 474.

Senate Bill 474 would require carriers to add certain information to the quarterly reports required to be filed under this section when the number of adverse decisions issued by a carrier for a type of service grows more than 10% in the preceding calendar year or 25% in the preceding three calendar years. If such an increase occurs, the bill requires carriers to report on changes in medical management contributing to the rise in adverse decisions, and "any other known reasons for the increase."

Furthermore, Senate Bill 474, would permit the Insurance Commissioner to use the information gathered from these reports as the basis for market conduct examinations under subtitle 2 of Title 2 of the Maryland Insurance Article.

Recent legislation in previous sessions has expanded the reporting required by health insurance carriers on adverse decisions, appeals, and grievances. The MIA has reviewed trends over time in adverse decisions and has noted considerable increases. Adverse decisions have more than doubled since 2015, while our fully insured market has shrunk. While adverse decisions as a percentage of covered lives were about 4.6% in 2015, they have since grown to encompass 12.7% of the fully insured market in 2023, with some service categories seeing growth rates in the triple digits.

The additional information that would be provided by carriers under Senate Bill 474 will help the MIA in setting priorities for enforcement. Acquiring further insights into adverse decisions will be essential for the MIA to better understand denials and prior authorization practices in the State and enhance patient care, as it may provide a more comprehensive understanding of the landscape of adverse decisions than is currently offered through the MIA's appeals and grievance process.

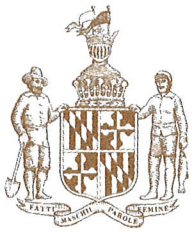
For these reasons, the MIA urges a favorable committee report on Senate Bill 474 and thanks the committee for the opportunity to share its support.

SB474 Testimony.pdf
Uploaded by: Pamela Beidle
Position: FAV

PAMELA G. BEIDLE
Legislative District 32
Anne Arundel County

Chair, Finance Committee
Executive Nominations Committee

Joint Committee on Gaming Oversight
Joint Committee on Management of Public Funds
Spending Affordability Committee



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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

February 12, 2025

Senate Bill 474
Health Insurance – Adverse Decisions
Reporting and Examinations

Good afternoon, Vice Chair Hayes and Member of the Finance Committee:

Thank you for the opportunity to present Senate Bill 474, Health Insurance – Adverse Decisions – Reporting and Examinations.

SB 474 seeks to provide the Maryland Insurance Administration with greater enforcement authority to ensure that health insurance carriers are not improperly issuing denials under Maryland's Appeals and Grievances law. Last Session, we passed a comprehensive bill to tighten timeframes, increase transparency, and broaden prior authorization policies under Maryland's appeals and grievances law. However, these laws only help Marylanders if the carriers comply.

Over the last several years, we have seen a significant increase in denials. We have all heard from constituents struggling to receive health care services despite paying high premium costs. Between 2019 and 2023, there has been an increase of 38.6% in adverse decisions reported by carriers. Over 109,000 adverse decisions were reported by carriers in 2023. Pharmacy services in particular saw a significant increase - about 71.6% - and account for the majority of the adverse decisions.

Therefore, Senate Bill 474 provides that if the carriers report more than a 10% increase in the number of denials in the immediately preceding calendar year or more than 25% in the immediately preceding three calendar years for a particular service, the carriers are required to submit a report to the Maryland Insurance Administration detailing any changes in medical management and any other reason for the increase. The Insurance Commissioner may then use this information to institute a market conduct examination.

Again, Maryland has strong laws, but we also need strong oversight to ensure compliance. I respectfully request a favorable report on Senate Bill 474.

Testimony in support of SB0474 - Health Insurance

Uploaded by: Richard KAP Kaplowitz

Position: FAV

SB0474_RichardKaplowitz_FAV

02/12/2025
Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON SB#/0474 - POSITION: FAVORABLE

Health Insurance - Adverse Decisions - Reporting and Examinations

TO: Chair Beidle, Vice Chair Hayes and members of the Finance Committee
FROM: Richard Keith Kaplowitz

My name is Richard Keith Kaplowitz. I am a resident of District 3. I am submitting this testimony in support of SB#/0474, Health Insurance - Adverse Decisions - Reporting and Examinations

Denials of care by medical insurers in Maryland have been rapidly increasing. This bill attempts to reign in this practice by those health insurers. As reported by WYPR on December 12, 2024:

> Two of Maryland's top three health insurers ranked above the industry average in claims denials in 2023.
>
> Both Blue Cross Blue Shield, known as CareFirst in the region, and UnitedHealthcare deny their beneficiaries' claims for medical procedures and appointments more than other companies in the field.
>
> CareFirst makes up 55% of Maryland's health insurance market share and denied 17% of claims in 2023, according to ValuePenguin, a consumer research site that specializes in insurance.
>
> The industry average is 16%.
>
> UnitedHealthcare denied 32% of claims in 2023 and makes up 9% of the state's market share.
>
> Kaiser Permanente is Maryland's second largest health insurer with 26% of the market, however, it only denied 7% of claims. However, Kaiser uses a different model than other insurance companies, often using in-house physicians for care. [1]

This bill will empower Maryland to take actions against these carriers for their adverse actions affected the health and lives of Marylanders. The bill will require certain carriers, if the number of adverse decisions issued by the carrier for a type of service has grown by more than 10% in the immediately preceding calendar year or 25% in the immediately preceding 3 calendar years, to provide certain information to the Maryland Insurance Commissioner. It then authorizes the Commissioner to use certain adverse decision information as the basis of a certain examination.

I respectfully urge this committee to return a favorable report on SB#/0474

[1] https://www.wypr.org/wypr-news/2024-12-12/two-of-marylands-top-health-insurers-deny-claims-at-high-rates

2025 MdAPA SB 474 Senate Side.pdf
Uploaded by: Robyn Elliott
Position: FAV

The Maryland Academy of Physician Assistants

mdapa

To: **Senate Finance Committee**

Bill: **Senate Bill 474 - Health Insurance - Adverse Decisions - Reporting and Examinations**

Date: **February 12, 2025**

Position: **Favorable**

The Maryland Academy of Physician Assistants supports *Senate Bill 474 – Health Insurance - Adverse Decisions - Reporting and Examinations*. This bill requires a carrier to submit a justification to the Insurance Commissioner if it experiences a rise in adverse decisions that equals more than 10% in the immediately preceding calendar year or 25% in the immediately preceding 3 calendar years.

According to data from a joint report of the Maryland Health Care Commission and Maryland Insurance Administration, adverse decisions in Maryland increased around seven percent from 2019 to 2022.[i] An adverse decision occurs when an insurance company denies a request for coverage or takes another action against a policyholder like increasing rates or terminating a policy. Without health insurance coverage, medical costs can increase exponentially, putting people into extreme debt that can lead to credit score damage, debt collection, lawsuits, garnishments, late fees and interest, bankruptcy, and delayed care. This increase in adverse decisions is concerning and prevents people from receiving appropriate and timely care. This bill well help explain the trend and can begin the process of reimagining health insurance in a way that benefits everyone.

We ask for a favorable report. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net.

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[i] Health Insurance – Utilization Review Revisions, An Environmental Scan of the Prior Authorization Process, November 21, 2024, https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/Health-Insurance-Utilization-Review-Revisions.pdf.

SB 474_FAV_MSHA.pdf
Uploaded by: Sarah Peters
Position: FAV

MARYLAND Speech · Language · Hearing Association
connect. learn. communicate.

February 10th, 2025

SB 474 - Health Insurance - Adverse Decisions - Reporting and Examinations

Position: SUPPORT

Dear Chair, Vice-Chair, and Members of the Committee:

The Maryland Speech Language Hearing Association (MSHA) represents speech language pathologists and audiologists across Maryland. We elevate and engage members to strive for excellence in serving those impacted by communication and related disorders through advocacy, equity, education, interprofessional collaboration, and leadership development.

On behalf of the MSHA, I am writing to express our strong support for SB 474 - Health Insurance - Adverse Decisions - Reporting and Examinations. This important legislation will require certain carriers to provide certain information to the Maryland Insurance Commissioner; and authorizing the Commissioner to use certain adverse decision information as the basis of a certain examination:

(1) if the number of adverse decisions issued by the carrier for a type of service has grown by more than 10% in the immediately preceding calendar year or
(2) 25% in the immediately preceding 3 calendar years

As speech-language pathologists and audiologists, we understand the importance of transparency when evaluating carrier's decision-making information. This ensures that carriers are abiding by the agreements established between themselves and health care providers, enabling Marylanders to receive the critical health care services to which they are entitled.

Therefore, this bill is a crucial step toward ensuring transparency and justice within healthcare decision-making and review. We urge you to support and advance SB 474 to ensure that your constituents receive necessary healthcare services.

Sincerely,

Megan Miskowski

Megan Miskowski, SLPD., CCC-SLP
Director of Advocacy and Public Policy
Maryland Speech Language Hearing Association

Maryland Speech-Language-Hearing Association
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Purcellville, VA 20132
301-304-7001
info@mdslha.org
www.mdslha.org

SB 474.pdf
Uploaded by: Taylor Dickerson
Position: FAV

MARYLAND
PSYCHOLOGICAL ASSOCIATION

PO Box 368 Laurel, MD 20725 410-992-4258 www.marylandpsychology.org

February 10, 2025

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Finance Committee
Miller Senate Office Building, 3 East
Annapolis, MD 21401

RE: SB474 Health Insurance – Adverse Decisions – Reporting and Examinations

Position: SUPPORT

Dear Chair, Vice-Chair and Members of the Committee:

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, asks the Senate Finance Committee to **FAVORABLY report on SB 474.**

We are writing to provide strong support for SB 474, which would require insurance companies to report to the Maryland Insurance Commissioner when adverse decisions have increased by more than 10% in the last year or 25% in the last three years. This legislation is essential for ensuring transparency and accountability within the insurance industry, allowing regulatory bodies to identify potential systemic issues that may negatively impact consumers. By mandating timely reporting of significant increases in adverse decisions, the bill will help protect policyholders from unfair practices and ensure that insurance companies are held to consistent standards of fairness and integrity. Enhanced oversight will ultimately contribute to a more equitable and trustworthy insurance system for all residents of our state.

If we can provide any additional information or be of any assistance, please do not hesitate to contact MPA's Legislative Chair, Dr. Stephanie Wolf, JD, Ph.D. at mpalegislativecommittee@gmail.com.

Respectfully submitted,

David Goode-Cross, Ph.D.
David Goode-Cross, Ph.D.
President

Stephanie Wolf, JD, Ph.D.
Stephanie Wolf, JD, Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

SB 474_Written_Testimony.pdf
Uploaded by: Vincent DeMarco
Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 474
Health Insurance - Adverse Decisions - Reporting and Examinations
Before the Senate Finance Committee
By Stephanie Klapper, Deputy Director, Maryland Citizens' Health Initiative, Inc.
February 12, 2025

Chair Beidle, Vice-Chair Hayes, and Members of the Senate Finance Committee, thank you for this opportunity to testify in support of Senate 474. I am submitting this testimony today aon behalf of our individual organization, Maryland Citizens' Health Initiative, Inc., as we have not reviewed this legislation with the full Maryland Health Care for All! Coalition. Our mission is to ensure that all Marylanders have access to quality affordable health care coverage.

This legislation if passed would require health insurance carriers to report to the Maryland Insurance Commissioner any changes in medical management contributing to the rise in adverse decisions for the type of service and any other known reasons for the increase if the number of adverse decisions issued by the carrier for a type of service has grown by more than 10% in the immediately preceding calendar year or 25% in the immediately preceding 3 calendar years. The Commissioner could then conduct an examination. One of Maryland consumers' top concerns is that they can depend on their health insurance carrier to approve their health care claims, or whether the care they need will be denied. A Commonwealth Fund survey found that 17% of respondents said that their insurer denied coverage for care that was recommended by their doctor; more than half said that neither they nor their doctor challenged the denial. Nearly six of 10 adults who experienced a coverage denial said their care was delayed as a result.

This legislation will help the Maryland Insurance Commissioner monitor rises in adverse decisions and the reasons why. We thank the Committee for its recognized efforts toward improving access to quality, affordable health care for all Marylanders. We urge the Committee to give a favorable report for Senate Bill 474.

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2025 MCHS SB 474 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FWA

Maryland Community Health System

Bill Number:	**Senate Bill 474 – Health Insurance – Adverse Decisions – Reporting and Examinations**
Committee:	**Senate Finance Committee**
Hearing Date:	**February 12, 2025**
Position:	**Support with Amendment**

The Maryland Community Health System (MCHS) strongly supports *Senate Bill 474 – Health Insurance – Adverse Decisions – Reporting and Examinations*. Under existing law, carriers must report on volume of adverse decisions. The legislation proposes that carriers should provide a comprehensive explanation behind the growth of adverse decisions, if the growth meets a certain threshold. The explanation would include changes in medical management regarding claims.

Maryland Community Health System is a network of federally qualified health centers providing primary, behavioral, and dental care to underserved communities throughout Maryland. Our health centers have been severely impacted by the growth in adverse decisions from private insurers and managed care organizations. The number of adverse decisions is beginning to compromise our health centers' ability to meet the health needs of their patients and communities.

We strongly support this bill, as it will provide needed information about the reasons behind the growth in adverse decisions. This information will support ongoing work by regulators, insurers and MCOs, and providers to understand how to address the issue.

We have an amendment request. As we read the existing law and the legislation, the reporting requirements only apply to state-regulated private plans. Many providers have also observed in a growth in adverse decisions from managed care organizations. We recommend that the committee consider an amendment to add managed care organizations to the reporting requirements.

We ask for a favorable with amendment report. If we can answer any questions, please contact Robyn Elliott at relliott@policypartners.net.