



State of Maryland
OFFICE OF THE ATTORNEY GENERAL

HEALTH INSURANCE CARRIER
APPEALS AND GRIEVANCES PROCESS

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

Submitted to the Governor and General Assembly

Insurance Article §15-10A-08
Commercial Law Article §13-4A-04

Fiscal Year 2026

Table of Contents

I.	Executive Summary	1
II.	Overview of the Appeals and Grievances Process	1
	A. State Law	1
	B. Federal Law	2
III.	Phases of the Appeals and Grievances Process	3
IV.	Carrier Reporting	3
	Carrier Statistics FY 2026	4
V.	Maryland Insurance Administration (MIA)	5
	MIA Statistics FY 2026	7
VI.	Health Education and Advocacy Unit (HEAU)	7
	A. HEAU Statistics FY 2026	8
	B. Appeals and Grievances Successes	9
	C. Additional HEAU Activities and Data	13
	D. Areas of Concern	14
	1. Hospital Facility Fees	14
	2. Other Out-of-Network Facilities	16
	3. Financing Products for Medical Expenses	17
	4. Additional Concerns	21
VII.	Conclusion	21
VIII.	Appendix	22
	A. Carrier Grievances Cases	
	1. Adverse Decisions, Grievances and Outcomes	23
	2. Denial Rate of Clean Claims	26
	3. Adverse Decisions – Prior Authorization	29
	4. Adverse Decisions – Step Therapy	31
	5. Non-Formulary Requests	33
	6. Number of Grievances Since FY 2016	35
	7. Outcomes	36
	8. Three Year Comparison of Outcomes	37
	9. Types of Services	38
	10. Outcomes by Service Type	39
	11. Two Year Comparison by Service Type	40

B. MIA Appeals and Grievances Cases	
1. Initial Review of Cases	41
2. Initial Disposition of Grievances	42
3. Carriers and Disposition	43
4. Disposition Following Investigation	45
5. Disposition Resulting from IRO Review	46
6. Types of Services Denied and Outcomes	47
C. HEAU Cases: Subject of Complaints	48
D. HEAU Appeals and Grievances Cases: Initial Disposition.....	49
E. HEAU Mediated Appeals and Grievances Cases	
1. Carriers, Regulatory Authority and Disposition	50
2. Disposition	56
3. Types of Carriers	57
4. Outcomes Based on MIA Regulatory Authority	58
5. Types of Denials	59
6. Outcomes by Denial Type.....	59
7. Timing of Denials	60
8. Outcomes by Timing of Denials	60
9. Who Filed the Case	61
10. Outcomes by Who Filed the Case	61
11. Types of Services Denied	62
12. Outcomes by Service Type	63

I. Executive Summary

The Health Education and Advocacy Unit (the “HEAU”) of the Office of the Attorney General’s Consumer Protection Division submits this annual report on the implementation of the Health Insurance Carrier Appeals and Grievances Law¹ (the “Appeals and Grievances Law”) as required by the Maryland Insurance Article §15-10A-08 and the Maryland Commercial Law Article §13-4A-04. Section 15-10A-08(b)(1) of the Maryland Insurance Article requires the HEAU to publish annually a summary report on the grievances and complaints filed with or referred to a carrier, the Commissioner of the Maryland Insurance Administration (the “MIA”), the HEAU, or any other federal or State government agency or unit during the previous fiscal year. Section 15-10A-08(b)(2) of the Maryland Insurance Article also requires the HEAU to evaluate the effectiveness of the internal grievance and complaint processes available to members, and to include in its annual summary report the results of this evaluation and any proposed changes to the law that the HEAU considers necessary.

This report covers grievances and complaints filed or referred during State Fiscal Year 2026, beginning July 1, 2025, and concluding June 30, 2026.

This report (1) summarizes the Appeals and Grievances Law; (2) discusses how health insurance carriers, the MIA, and the HEAU implement the Appeals and Grievances Law; (3) summarizes grievances and complaints handled by carriers, the MIA and the HEAU; and (4) provides additional information about HEAU activities and legislative recommendations to strengthen consumer protections in the health care marketplace.

II. Overview of the Appeals and Grievances Process

State Law

In 1998, the General Assembly enacted the Appeals and Grievances Law to provide patients a process for appealing their health insurance carriers’² medical necessity “adverse decisions.” All carriers must establish a grievance process that complies with the Appeals and Grievances Law. The Appeals and Grievances Law established guidelines that carriers must follow in notifying patients of denials, establishing appeals and grievances processes, and notifying members of grievance decisions.

In 2000, the General Assembly enacted Chapter 371³ that expanded the grievances process to include the right to appeal contractual “coverage decisions.”

¹ Md. Code Ann., Ins. §15-10A-01 through §15-10A-10.

² The Appeals and Grievances Law currently defines “carrier” as a person that offers a health benefit plan and is: (1) an authorized issuer that provides health insurance in the State; (2) a nonprofit health service plan; (3) a health maintenance organization; (4) a dental plan organization; (5) a self-funded student health plan operated by an independent institution of higher education...that provides health care to its students and their dependents; or (6) except for a managed care organization ... any other person that provides health benefit plans subject to regulation by the State. Md. Code Ann., Ins. §15-10A-01(c).

³ Md. Code Ann., Ins. §15-10D-01 through §15-10D-04.

In 2011, the General Assembly enacted Chapters 3 and 4,⁴ which expanded the definition of “coverage decisions” to include a carrier’s decision that someone is ineligible for coverage or a carrier’s decision that results in the rescission of an individual’s coverage.

In 2022, the General Assembly enacted Chapter 229⁵ to implement section 110 of the federal No Surprises Act requiring, among other things, that the external review process apply with respect to any adverse determination by a carrier under Public Health Service Act sections 2799A-1 (preventing surprise medical bills for out-of-network emergency services and services by out-of-network providers at in-network facilities) and 2799A-2 (ending surprise air ambulance bills).

As a result, patients with Maryland-regulated plans are able to challenge any decision by a carrier that results in the total or partial denial of a covered health care service, the denial of eligibility for coverage, the rescission of coverage, or the failure to apply the cost-sharing and surprise billing protections in the No Surprises Act.

Maryland law has two similar processes for patients to dispute carrier determinations: one for carriers’ denials that proposed or delivered health care services are not or were not *medically necessary* (“adverse decisions”), and another for carriers’ determinations that result in the *contractual exclusion* of a health care service (“coverage decisions”).

Federal Law

Under the Patient Protection and Affordable Care Act (the “ACA”) and the No Surprises Act, consumers have the right to appeal health plans’ decisions rendered after March 23, 2010. Guidance and regulations issued by the U.S. Departments of Health and Human Services (“HHS”), Labor, and Treasury⁶ standardized internal claims and appeals and external review processes for group health insurance plans and health insurance issuers offering coverage in the group and individual markets. Under the regulations, consumers have the right to:

1. Information about why a claim or coverage has been denied and how they can appeal that decision;
2. Appeal to the insurance company to conduct a full and fair review of its decision (*internal appeals*); and
3. Appeal to an independent third-party review organization (“IRO”) for review of the carrier’s decision (*external review*) for claims that involve (a) medical judgment (including but not limited to those based on the plan’s requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer; (b) a rescission of coverage (whether or not the

⁴ Chapters 3 and 4 made other changes to processes and rights under the Appeals and Grievances Law that became effective July 1, 2011.

⁵ Md. Code Ann., Ins. §15-146(b) (application of No Surprises Act)-(d) (MIA No Surprises Act enforcement authority).

⁶ 26 CFR Parts 54 and 602 (Treasury); 29 CFR 2590 (Labor); 45 CFR 147 (HHS) (October 7, 2021).

rescission has any effect on any particular benefit at that time); or (c) surprise billing and cost-sharing prohibited under the No Surprises Act.

Accordingly, Maryland continues to implement the Appeals and Grievances Law as described below.

III. Phases of the Appeals and Grievances Process

For both adverse decisions and coverage decisions, the appeals and grievances process begins when a patient receives notice from the carrier that the carrier has rendered an adverse decision or coverage decision. Carriers must provide patients with a written notice that clearly states the basis of the carrier's adverse or coverage decision, and that the HEAU is available to mediate the dispute with the carrier or, if necessary, help the patient file a grievance or appeal. Patients may file a complaint with the MIA or other external reviewer prior to exhausting the internal grievance process only when there is a compelling reason.

After receiving the initial denial, the patient⁷ may contest the determination through the carrier's internal grievance or appeal process. After receiving the grievance or appeal, the carrier has 30 working days to review adverse decisions involving pending care and 45 working days for already-rendered care. Emergency cases must be reviewed within 24 hours. For coverage decisions, the carrier has 60 working days after the date the grievance was filed with the carrier to render a decision. The carrier must issue a written decision to the patient at the conclusion of this internal process.

If the carrier's final decision is unfavorable, the patient may file a complaint with the MIA or other external reviewer for an external review of the carrier's adverse decision or coverage decision involving medical judgment. Other coverage decisions of carriers regulated by the MIA can be appealed to the MIA under State law. The ACA's implementing regulations did not extend external review rights for coverage decisions based strictly on contractual language unrelated to any medical judgment.

IV. Carrier Reporting

The Appeals and Grievances Law requires carriers to submit quarterly reports to the MIA on the number of adverse decisions issued and the number and outcomes of internal grievances. The MIA then forwards this data to the HEAU for inclusion in this report. Until recently, however, the carriers were not required to report on total enrollee numbers or total claims processed, so no proportional analysis of how frequently claims were denied was possible. 2024 Maryland Laws Ch. 891 (HB 1337) updated the reporting requirements, effective July 1, 2024, to include (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 (i.e., "enrollee numbers"); and (2) the number of clean claims for reimbursement processed by the carrier (i.e., "clean claim numbers"). This report includes that carrier-reported data. This data reflects medical necessity denials in relation to clean claims, which

⁷ Throughout this report, we refer to the rights of patients during the appeals and grievances process. The Appeals and Grievances Law also gives health care providers and, pursuant to Chapters 3 and 4 of 2011, the patient's representative, if any, the right to file appeals and grievances on behalf of patients.

excludes coverage denials and denials for administrative issues, coding errors, paperwork problems, and other non-specified reasons. As such, the value of the reported data is quite limited for the purpose of determining the percentage of claims that were denied; according to a recent Kaiser Family Foundation report, only 5% of denials are based on medical necessity.⁸

2024 Maryland Laws Ch. 847 (HB 932), effective January 1, 2025, updated the carrier reporting requirements to include (1) whether the adverse decision involved a prior authorization or step therapy protocol; (2) the number of adverse decisions overturned after a reconsideration request; and (3) the number of formulary exception requests made and the outcome of those requests. This report includes that carrier-reported data.

2025 Maryland Laws Ch. 669 (HB 848), effective October 1, 2025, further updated the carrier reporting requirements, requiring the currently reported data to be aggregated by zip code, and requiring carriers to identify instances when the number of adverse decisions has grown by 10% or more for any given service type in the immediately preceding calendar year or 25% in the immediately preceding three calendar years. Carriers are also required to explain the reasons for the increase. This report does not include that data, which would not encompass the full fiscal year.

2025 Maryland Laws Ch. 747 (HB 820), effective October 1, 2025, further updated the carrier reporting obligations, requiring reporting about whether an artificial intelligence, algorithm, or other software tool was used in making the reported adverse decisions. This report does not include that data, which would not encompass the full fiscal year.

For all categories, the data included in this report was not completely verified by the HEAU, but the HEAU did notify the MIA where anomalies (missing quarterly data, outliers) were identified.

Current data reveals that in the last ten fiscal years, on average, only 10% of adverse decisions are challenged, and on average, 54% of those grievances are reversed.

Carrier Statistics FY 2026

In addition to the highlights below, statistical details from the data submitted by carriers appear in charts on pages 23-40 of this report.

1. Carriers reported 144,532 adverse decisions, 27,013 more adverse decisions than reported in FY 2025, a 23% increase.

⁸ Michelle Long, Justin Lo & Kaye Pestaina, *Claims Denials and Appeals in ACA Marketplace Plans in 2024* (KFF, Mar. 24, 2026), analyzing federal transparency data released by the Centers for Medicare and Medicaid Services (CMS) on claims denials and appeals for non-group qualified health plans (QHPs) offered on HealthCare.gov in 2024, revealed that insurers of QHPs sold on HealthCare.gov denied 19% of in-network claims in 2024 and 37% of out-of-network claims for a combined average of 20% of all claims, similar to 2023. The most common reason cited by insurers was “Other” at 36%, followed by administrative reasons (25%), lack of prior authorization or referral (9%), and only 5% based on lack of medical necessity. <https://www.kff.org/patient-consumer-protections/claims-denials-and-appeals-in-aca-marketplace-plans-in-2024/> (last accessed September 18, 2026).

2. Consumers challenged only 8.8% of the adverse decisions.
3. When challenged, carriers overturned or modified their original adverse decision 52% of the time.
4. Nearly half of all adverse decisions reported for the period involved prior authorization, with carriers collectively attributing 47.26% of adverse determinations to prior authorization activity. Several carriers issued most of their adverse decisions at the pre-service stage, indicating a strong reliance on prior authorization for medical-necessity review. In contrast, many carriers reported little or no prior authorization-related adverse decision activity, reflecting differences in benefit design, utilization management practices, or reporting completeness. Overall, the findings demonstrate substantial variation among carriers but clearly confirm that prior authorization remains a central driver of adverse decisions across the market.
5. As reported, step therapy accounted for just 1,000 cases – 0.69% of all adverse decisions reported. However, most carriers reported no step-therapy-related adverse decisions, indicating either an absence of step-therapy requirements in their benefit designs or no reported activity during the period.
6. Non-formulary drug requests showed a relatively high overall denial rate, with carriers denying 46.61% of all non-formulary requests submitted during the period. While many carriers reported no activity, reflecting either an absence of non-formulary drug requests or incomplete reporting (notably for Quarter 3 of 2025), the carriers that did report data exhibited a wide range of denial behavior. Overall, the data demonstrates significant variation across carriers but reflects a generally high level of denial for non-formulary drug requests.
7. The largest percentages of denials were in the pharmacy (44%), lab/radiology (23%), and dental (21%) categories.
8. The largest percentages of grievances filed were in the pharmacy (51%), lab/radiology (21%), dental (15%), and physician (8%) service categories.
9. Fifty percent or more of pharmacy (56%), PT/OT/speech therapy (56%), physician (51%), and other (obesity, IVF, podiatry, hearing and vision) (60%) adverse decisions grieved were overturned or modified.

V. Maryland Insurance Administration (MIA)

The MIA has regulatory oversight of insurance products offered in Maryland. In 1998, the Appeals and Grievances Law was enacted by the General Assembly to provide a fair process for resolving disputes regarding the medical necessity of a proposed or delivered health care service. (*See*, Title 15, Subtitle 10A of the Insurance Article.) Until July 1, 2011, the Appeals and Grievances Law applied only to individuals with insured health benefits. However, because of the ACA expansion of

external appeal rights, the Department of Budget and Management for the State of Maryland and Cecil County Public Schools elected to use the Maryland Insurance Administration's external review process to provide external review for their self-funded employee health benefit plans.⁹

When the MIA receives a written complaint from a member, a member's authorized representative, or a health care provider or facility, the MIA will review it to determine if the complaint raises issues subject to the Appeals and Grievances Law. If the Appeals and Grievances Law applies the MIA confirms the insurance carrier's internal grievance process has been fully exhausted, unless there is a compelling reason for the MIA to act prior to the exhaustion process. If the carrier's internal process has been exhausted or if there is a compelling reason to bypass the internal grievance process, within five working days of receipt of the complaint, the MIA will contact the carrier to request a written response to the complaint. Unless an extension request from the carrier is granted by the MIA, the carrier shall respond to the MIA within seven working days (except emergency issues, which must be resolved within 24 hours), and the carrier must respond to the MIA by providing medical and claims information (including the health benefit contract) pertinent to the complaint and either uphold, reverse, or modify its denial. When the MIA does not have jurisdiction over the complaint or the carrier's internal grievance process has not been exhausted, the MIA refers the complainant to the HEAU so the member, the member's authorized representative, or the health care provider or facility can be assisted through the carrier's internal grievance process or external review process as applicable.

If the carrier upholds a denial that is subject to the Appeals and Grievances Law, then the MIA will prepare the case for review. As part of the preparation, the MIA will contact the complainant and the carrier in writing, giving them a deadline for submitting additional documentation to be considered in the review as applicable. Once the MIA receives the proper documentation, the case is then forwarded to an IRO for a medical necessity review via the IRO's electronic portal. In selecting an IRO, the MIA ensures that the IRO has an appropriate board-certified physician available to review the case. Upon receipt of the case from the MIA, the IRO then transmits the case to its expert reviewer, who researches and reviews the case, renders an opinion, and transmits the opinion back to the IRO. The IRO, in turn, conducts a quality review of the expert reviewer's opinion. For medical necessity reviews, the MIA asks the IRO to respond to specific questions as set forth in a cover letter attached to the complaint. The IRO will orally inform the MIA of the expert reviewer's determination and follow up with the written determination via electronic mail. If the IRO reviewer's recommendation is to overturn, uphold, or modify the carrier's denial, the MIA may accept this recommendation and base its final closing letter on the professional judgment of the IRO reviewer. The complainant may be notified in writing of the outcome via electronic mail, U.S. mail, or facsimile. The MIA also forwards a copy of the IRO's medical opinion to the carrier via the MIA's licensee portal. In all instances, the carrier that is the subject of the complaint must pay the expenses of the IRO selected by the MIA. Hearing rights to contest the MIA decision are given to all consumers, except

⁹ While the MIA only conducts the external review for people with insured health benefits and the Department of Budget and Management for the State of Maryland and Cecil County Public Schools, with the exception of grandfathered plans, the ACA mandates external review processes for all group health insurance plans and health insurance issuers offering coverage in the group and individual markets. Grandfathered plans are subject to the external review process of adverse benefit determinations for claims subject to the cost-sharing and surprise billing protections of the No Surprises Act.

for individuals covered under the State of Maryland employee/retiree plan. Carriers do not have a right to an administrative hearing but may file a petition for judicial review.

Maryland law requires the MIA to make a final decision on complaints within 45 calendar days of receipt of the complaint. However, the MIA can extend cases for an additional 30 working days if information requested by the MIA has not been received. For emergency or compelling cases, the MIA will conduct an expedited external review, completing the above process within 24 hours of receipt of the complaint. A hotline number (800-492-6116) is available 24 hours a day, seven days a week to respond to these emergency or compelling cases.

MIA Statistics FY 2026

MIA-provided data are reported in the charts and tables contained on pages 41-47 of this report. The data reflect only those cases where a disposition has been rendered; pending cases are not reported.

In addition to the data reflected in the charts and tables, the MIA-reported data reveal:

1. The MIA's Appeals and Grievances Unit received 1,399 complaints in FY 2026. After reviewing these complaints, the MIA determined that 613 involved MIA-regulated adverse decisions.
2. The MIA referred 64 complainants to the HEAU because the complainant had not yet exhausted the carrier's internal grievance process. The MIA investigated 549 complaints.
3. The **MIA modified or reversed the carrier's grievance decision, or the carrier reversed its own decision during the MIA's review, in 68% of cases.** The MIA upheld the carrier's original decision in 32% of cases.
4. Like FY 2024 and 2025, the largest percentages of grievances filed involved pharmacy services/formulary issues (44%); lab, imaging, and test services (23%); physician services (10%); and dental care (7%).

VI. Health Education and Advocacy Unit

The Maryland General Assembly established the Health Education and Advocacy Unit (HEAU) in 1986. The HEAU was designed to assist health care consumers in understanding health care bills and third-party coverage, to identify improper billing or coverage determinations, to report billing or coverage problems to appropriate agencies, including the Consumer Protection Division's Enforcement Unit, and to assist patients with health equipment warranty issues. Based upon the HEAU's successful efforts in these areas, the General Assembly selected the HEAU to be the State's first-line consumer assistance agency when it passed the Maryland Appeals and Grievances Law. Following passage of the ACA and the implementation of Maryland's Health Benefit Exchange, the HEAU began helping consumers who encountered problems enrolling on the Exchange and obtaining premium tax credits and cost-sharing reductions.

The Appeals and Grievances Law requires carriers to notify patients that the HEAU is available to assist them in mediating and filing a grievance or appeal of an adverse decision or coverage decision. The notice must also include the HEAU's address, telephone number (410-528-1840), facsimile number (410-576-6571), and email address (heau@oag.maryland.gov).

When the HEAU receives a request for assistance, the HEAU gathers basic information from the carriers related to the services or care denied. Specifically, the HEAU asks the carrier to provide a copy of the insurance contract provisions and the utilization review criteria upon which the carrier based the denial and to identify precisely which provisions or criteria the patient purportedly failed to meet. Carriers must provide the requested information to the HEAU within seven working days from the date the carrier receives the request. The HEAU also gathers the necessary medical information from the patient and the patient's provider to support the appeal. The HEAU presents this information to the carrier for reconsideration of the denial. Many complaints are resolved during this information exchange process. If not resolved, the HEAU will prepare and file a formal written grievance or appeal with the carrier on behalf of the patient.

If, at the conclusion of the internal appeals and grievances process, the carrier continues to deny coverage for the care, the HEAU prepares an external appeal of the carrier's decision. The HEAU forwards the case to the MIA or other external entity with a copy of all relevant medical and insurance documentation, and the HEAU monitors the outcome of the external review.

A. HEAU Statistics FY 2026

The HEAU Appeals and Grievances data¹⁰ are reported in the charts and tables contained on pages 48-63 of this report. The data reflect medical necessity, contractual, and eligibility denials. Because newly filed cases contain incomplete data, this report includes only those cases the HEAU closed during FY 2026.

The HEAU closed 2,431 cases in FY 2026.

1. 39% of the complaints closed by the HEAU involved "carriers," defined in this report to include insurers, nonprofit health service plans, HMOs, dental plan organizations, third-party administrators, utilization review agents, pharmaceutical benefit management companies, and any other entity that provides health benefit plans or adjudicates claims.
2. 10% of the complaints closed by the HEAU involved consumers requesting assistance with Maryland Health Connection-related issues.
3. 819 of the complaints closed by the HEAU were cases involving appeals and grievances. Not all of the 819 appeals and grievances complaints filed with the HEAU were mediated. Some consumers, or other people acting on their behalf, file complaints

¹⁰ Detailed data related to the outcomes of cases handled by the HEAU unrelated to the Appeals and Grievances Law are not contained in this report; some general complaint numbers and categories are reported for informational purposes.

but never complete an authorization to release medical records form or an authorized representative form (for Maryland Health Connection cases), which the HEAU requires to mediate the case. Other complaints are filed for the record only or are referred to a more appropriate agency. Of the 819 appeals and grievances cases the HEAU closed, 480 (59%) involved assisting consumers with mediating or filing grievances of adverse or coverage decisions. Some of the cases involved more than one carrier.

4. Of the 480 appeals and grievances cases the HEAU mediated, 33% were adverse decision (*medical necessity*) cases, 56% were coverage decision (*contractual exclusion*) cases, and 11% were eligibility cases.
5. **The HEAU's mediation efforts led to changed outcomes in 53% of the cases.** Among these, 50% of medical-necessity cases, 51% of coverage-decision cases, and 65% of eligibility-denial cases were overturned or modified.
6. HEAU mediation efforts resulted in a decision change in 62% of cases involving at least one MIA-regulated plan. In cases involving non-regulated plans, the HEAU's efforts resulted in a decision change 44% of the time.
7. The HEAU assisted patients in recovering or saving over \$6.5 million, including over \$5.5 million in appeals and grievances cases.

B. Appeals and Grievances Successes

Consumers continue to receive significant benefits from Maryland's Appeals and Grievances Law and HEAU assistance. When carrier denials were challenged by the HEAU, 53% were overturned or modified during the reporting period. Positive results for the consumers who reach the HEAU notwithstanding, this reversal rate suggests carriers are inappropriately denying claims in the first instance, and the resulting delays burden consumers medically, financially, and emotionally.

Some examples from cases mediated by the HEAU this year highlight the importance of consumer assistance when challenging claim payment avoidance by carriers and health care claim denials.

1. A child with phenylketonuria (PKU), a rare metabolic disorder, requires continuous drug treatment. When forced to switch from brand-name Kuvan to generic sapropterin dihydrochloride, the consumer experienced significant adverse effects, including emotional dysregulation, anxiety, and sensory challenges, making the generic formulation medically inappropriate. Moreover, the child's provider recommended alternate therapy to address insufficient metabolic support. A note in the child's medical record indicated that the denial of the brand-name drug "could lead to brain damage."

Despite strong physician support and clear documentation of medical necessity, the carrier denied coverage for both brand-name Kuvan and an alternate therapy, Sepiience (generic name: sepiapterin), leaving the child without any viable PKU treatment. Interrupting therapy placed the child at immediate risk of metabolic instability and neurologic harm.

The HEAU intervened, and Sephience was ultimately approved. Because the medication carries an estimated list price of \$40,000–\$41,000 per month, or \$480,000–\$492,000 per year, coverage was essential for the child’s continued care.

2. A young adult diagnosed with testicular cancer required a Retroperitoneal Lymph Node Dissection (RPLND), a highly specialized procedure reportedly performed by a single identified urologist within the consumer’s area. Unfortunately, this surgeon was out of network under the consumer’s insurance plan and not approved by the carrier. Instead, the carrier provided a list of 66 in-network specialists, none of whom were qualified to perform the surgery. After receiving the complaint, the HEAU submitted an urgent appeal requesting an out-of-network exception based on network inadequacy. The carrier overturned its initial decision and approved treatment with the out-of-network specialist at an out-of-network facility, ensuring the consumer could receive the necessary surgery.
3. A child diagnosed with Duchenne Muscular Dystrophy, who met clinical criteria for Elevidys, an FDA-approved gene therapy for ambulatory boys ages four and older, was denied coverage of the life-altering medication. The provider initially submitted an authorization request through the pharmacy benefit, but the pharmacy responded that Elevidys was not covered under that benefit and instructed the provider to submit the request through the medical benefit. Attempts to obtain coverage through the medical benefit were unsuccessful due to coding issues. The provider was then informed by the carrier that no prior authorization would be issued because Elevidys was considered experimental and investigational, and therefore not a covered service.

The provider sought the HEAU’s assistance on behalf of the family. Our office submitted an urgent request for coverage documenting the medication’s efficacy and medical necessity to slow the progression of the child’s debilitating neuromuscular disease.

After continued advocacy, the carrier ultimately approved coverage, allowing the child to receive the urgently needed one-time gene therapy. Elevidys, which has a U.S. list price of \$3.2 million per patient, is administered as a single-dose infusion and is among the world’s most expensive medicines.

4. In October 2024, a consumer with Posterior Cortical Atrophy (PCA), a rare, atypical variant of Alzheimer’s disease and neurodegenerative condition that affects the back of the brain and causes severe visual and spatial-processing impairment, contacted the HEAU for assistance when her carrier denied coverage for lecanemab, deeming the drug experimental/investigational for all indications. Lecanemab is an FDA-approved Alzheimer’s treatment, covered by Medicare, that reduces amyloid plaque in early Alzheimer’s disease. The HEAU successfully appealed the denial, resulting in approved coverage of the drug through the end of 2025.

In May 2025, however, the carrier abruptly reversed its decision and again denied treatment as experimental/investigational, without any clinical basis. The consumer returned to the HEAU for assistance. Over the following months, the HEAU worked with the carrier to resolve what the insurer later described as a system error that bypassed the prior approval and incorrectly pended the claims for medical review, resulting in repeated denials. The carrier ultimately reprocessed and approved the claims, saving the consumer \$4,234.

5. A child under the age of two presented to a dentist with severe tooth decay and suspected abscesses requiring urgent treatment, including diagnostic radiographs, extractions, crowns, and possible root-canal therapy. Because the child was uncooperative and needed to be physically restrained during the examination, the provider determined that the procedures could only be performed safely under general anesthesia in a hospital setting. The provider's care coordinator contacted the family's medical carrier to obtain prior authorization for hospital and anesthesia services and was twice assured that no prior authorization was required and that the hospital-based procedure would be fully covered.

Despite these assurances, the carrier later denied both the \$7,676.92 hospital claim and the \$1,330 anesthesia claim, stating that the plan only covered treatment for an injury or illness. The family appealed, resulting in payment of the anesthesia claim and adjustment of the hospital claim; however, the carrier incorrectly applied the allowed amount (\$7,523.38) for the hospital claim to the member's in-network coinsurance, leaving the family responsible for the full balance. The consumer then contacted the HEAU for assistance. Following the HEAU's outreach, the carrier reprocessed the hospital claim correctly, removing all member liability and saving the family \$7,523.38.

6. In the HEAU's FY 2024 Annual Report, we described a case in which a carrier improperly denied coverage for a cycle of dry needling treatment, labeling the therapy "experimental/investigational" despite its recognized safety and effectiveness, and despite the treating provider's determination that it was medically necessary. Dry needling had been the only intervention that provided the consumer meaningful relief—reducing pain, improving range of motion, and allowing them to function without reliance on strong pain medications. That denial was overturned on external review with the Maryland Insurance Administration.

In a similar case in FY 2026, the consumer depended on dry needling performed by their physical therapist to manage significant hip and leg pain and diffuse muscle weakness. Without this minimally invasive therapy, the consumer would have required powerful pain medications that would have impaired daily functioning, including driving and work activities. Nevertheless, the same carrier again issued an adverse decision, denying reimbursement and continuing to assert that dry needling was experimental or investigational.

The HEAU assisted the consumer, and after the carrier upheld the denial during the internal appeal process, the HEAU sought an external review with the Maryland Insurance Administration. As in the 2024 case, the external reviewer concluded that dry needling is a recognized therapeutic intervention for myofascial pain syndromes and is not considered experimental/investigational. The reviewer overturned the denial, resulting in coverage and saving the consumer \$340.

7. An oncologist prescribed a Positron Emission Tomography/Computed Tomography (PET/CT) scan for a consumer with stage 4 breast cancer with bone and liver metastases to assess disease progression and evaluate treatment effectiveness. Despite its clinical value and the oncologist's determination that the scan was medically necessary for the patient,

the carrier denied prior authorization. Because the PET/CT scan was essential to guide ongoing cancer treatment, the consumer proceeded with the scan, knowing she faced a financial risk. Although the carrier initially reimbursed the claim, it later retroactively denied payment based on the original prior authorization denial. The consumer, the prescribing oncologist, and the HEAU each submitted appeals, all of which were upheld through the carrier's internal appeal process. The denial was ultimately reversed following an independent external review, saving the consumer \$2,000.

8. A consumer sought reimbursement for hearing aids purchased from an out-of-network provider after first obtaining prior authorization from his carrier. Although the prior authorization was approved, the claim was later denied for lack of necessary documentation. The carrier requested the retailer's tax ID and NPI number, the procedure code, and the diagnosis code. Despite multiple submissions of the requested information, the carrier continued to deny the claim, prompting the consumer to contact the HEAU for assistance.

After receiving the complaint, the HEAU resubmitted all required information to the carrier. When several months passed without any response, the HEAU escalated the matter to the Office of Personnel Management. Ultimately, one year after the consumer purchased the hearing aids, the claim was paid, saving the consumer \$1,599.99.

9. A consumer seeking specialty care spent several weeks working with her carrier to ensure that her primary care provider (PCP), a clinician who treats both pediatric and adult patients, was correctly designated in the carrier's records. Although the carrier initially stated that the provider was out-of-network, the consumer supplied proof of network participation and was assured that her PCP designation had been updated accordingly.

Her PCP subsequently referred her to a bariatric specialist for evaluation and treatment. Despite the referral, the consumer's initial visit was denied for lack of a referral. The consumer contacted the carrier multiple times and repeatedly provided documentation showing that the referral had been made, yet the carrier continued to deny coverage. After numerous unsuccessful attempts to resolve the issue, the consumer contacted the HEAU for assistance.

In response to the HEAU's outreach, the carrier explained, for the first time, that the denial stemmed from the PCP being coded internally as a pediatric-only provider with an age limit of 21, rendering the referral invalid because the consumer was older than that age. The carrier explained that it contacted the PCP's office and confirmed that the provider maintained an adult practice. The carrier subsequently corrected the PCP record and reprocessed the claim, saving the consumer \$250 and allowing her continued specialty care.

10. A consumer who required skilled nursing care encountered significant hardship after his carrier denied continued care coverage for the services. To prevent a dangerous interruption in care, the consumer paid \$15,621 out of pocket directly to the facility and appealed the denial. An Administrative Law Judge ultimately overturned the carrier's decision. Although the carrier subsequently paid the facility, the facility refused to refund the

consumer's payment. After multiple unsuccessful attempts to recover the funds, the consumer contacted the HEAU for assistance. The HEAU intervened on the consumer's behalf and secured a full refund of the \$15,621 the consumer was owed.

11. A consumer visited her in-network provider in May 2024 for an annual preventive care visit, a service fully covered by her insurance plan. However, the provider did not submit the claim within the carrier's timely-filing deadline, resulting in a denial. Although the provider insisted the claim had been submitted on time and urged the carrier to reconsider, the denial was upheld. The provider then billed the consumer, even though she had no control over the filing error and no financial responsibility for a preventive service that should have been fully covered. After the consumer made several unsuccessful attempts to resolve the issue with the provider, she contacted the HEAU. Our office mediated with the provider, and the charge was ultimately waived, saving the consumer \$269.

C. Additional HEAU Activities and Data

The HEAU also assists consumers with medical billing, equipment, and records disputes; problems enrolling on the Exchange and obtaining premium tax credits and cost-sharing reductions; and obtaining financial assistance and income-based payment plans from hospitals.

In FY 2026, the top ten categories in which the HEAU received the largest number of non-appeals-related cases were:

- Billing - Patient Feels that Charges are Too High
- Assistance Request - Consumer Requesting Information or Response to Question
- Quality of Care - Consumer Displeased with Quality of Care
- Billing - Billed for Services Not Performed
- Billing - Consumer Seeks Itemized Bill or Clarification of Charges
- Billing - Failure to refund overpayment
- Enrollment - APTC/CSR Dispute
- Assistance Request - Consumer Requesting Charity Care/Financial Assistance
- Medical Records - Patient Requesting Copies of Medical Records
- Billing - Billed for Charges Already Paid

The HEAU continues to monitor and offer consumer-centric input to state and federal agencies involved in health policy decision making. The HEAU's director served as a consumer representative, either as a member or in an *ex officio* capacity, on the Maryland Health Benefit Exchange's Standing Advisory Committee and the Protected Health Care Commission.

The HEAU also provided consultative and litigation support to the Office of the Attorney General in its efforts to advance and defend the consumer protections afforded to Marylanders by the Affordable Care Act and other federal and State laws, joined amicus briefs, and commented on federal and State regulations supporting efforts to enhance consumer protections in the health care marketplace.

D. Areas of Concern

1. Hospital Facility Fees

During the 2019 and 2020 sessions, the HEAU sought legislation to address the growing prevalence of hospital outpatient facility fees and the financial harms consumers suffered due to these surprise charges. Ultimately, the Facility Fee Right to Know Act was passed, requiring that consumers be given specific statutorily prescribed notice of a small subsection of the outpatient fees. Md. Code Ann., Health Gen. §19-349.2. The HEAU advocated for a statutory notice for all outpatient facility fees but in a last-minute amendment, hospitals sought and obtained a significant limitation, requiring that statutory notice be provided only to consumers scheduled for “clinic services” that are not otherwise billed in another rate center. Consumers continue to be blindsided by surprise facility fees when they obtain the following types of services:

- a. Diagnostic Radiology, Ultrasound, and Vascular
- b. Nuclear Medicine
- c. Radiology Therapeutic
- d. Electrocardiography
- e. Electroencephalography
- f. Physical Therapy & Occupational Therapy
- g. Respiratory Therapy & Pulmonary Function Testing
- h. Leukapheresis
- i. Labor and Delivery
- j. Interventional Radiology/Cardiovascular
- k. Ambulance Services – Rebundled
- l. Speech Therapy
- m. Audiology
- n. Laboratory Services
- o. CT/MRI

At the time, Maryland was one of only a few states to address these burgeoning fees, but state and federal lawmakers and consumer advocacy groups across the country are pursuing reforms to reduce the surprise and the consumer and employer health care costs associated with facility fees. Georgetown University’s Center on Health Insurance Reforms recently published several reports, *Regulating Outpatient Facility Fees: States are Leading the Way to Protect Consumers*,¹¹ *Facility Fee Reforms: How States Are Tackling Excessive Charges*, June 2025,¹² and *The Latest Research and Action on Facility Fee Reform*,¹³ exploring how and why many states are taking on the regulation of these fees.

¹¹ Christine Monahan, Karen Davenport, Rachel Swindle & Hanan Rakine, *New Georgetown Report and Issue Brief on Outpatient Facility Fee Billing and State Policy Responses* (CHIR Faculty, July 20, 2023), <https://chir.georgetown.edu/new-georgetown-report-and-issue-brief-on-outpatient-facility-fee-billing-and-state-policy-responses/> (CHIR Faculty, June 17, 2025) (last accessed September 22, 2026).

¹² How States Are Tackling Excessive Charges: Facility Fee Reforms, YouTube, <https://www.youtube.com/watch?v=78MpXSbNjCo> (last accessed September 22, 2026).

¹³ Kennah Watts & Julia Burleson, *The Latest Research and Action on Facility Fee Reform*, Center on Health Insurance Reforms (CHIR Faculty, Aug. 12, 2026), <https://chir.georgetown.edu/the-latest-research-and-action-on-facility-fee-reform/> (last accessed September 22, 2026).

During the 2024 session, the Office of the Attorney General sought legislation requiring a statutory notice be provided for facility fees billed in the majority of rate centers outlined above, and by out-of-state hospitals billing facility fees in Maryland outpatient settings. As a result, the Health Services Cost Review Commission (HSCRC) was tasked by [SB 1103](#) to study and report further on expanding statutory notice requirements and provide research on the impact, purpose, and feasibility of continued facility fee charges.

In December 2024, in its Report on [Facility Fees and Facility Notices](#),¹⁴ the HSCRC recommended requiring all non-profit and for-profit hospitals providing outpatient services in the State, whether or not the hospital's rate is regulated by the HSCRC, to provide notice of facility fees for outpatient services that are:

- Provided in the State of Maryland; and
- Have both a hospital charge (facility fee) and a professional charge.

However, it recommended waiting until the 2026 session to allow the HSCRC to complete the evaluation of the effectiveness of the current notice. The HSCRC's recommended expansion of the notice included a carve-out for inpatient services, emergency department services, emergent services, laboratory/pathology services and professional fees. The HEAU fully supports expansion of the notice but disagrees with the recommendation to carve out laboratory/pathology services because consumers often face higher cost sharing for hospital-based labs and do not expect to face facility fees for such services. The HEAU believes that consumers who visit hospital outpatient settings should not be blindsided by unexpected charges and supports expanded notice. Indeed, blindsiding patients with charges is inconsistent with the requirements of the Consumer Protection Act. This issue has urgency for consumers because the burden of paying the fee out-of-pocket falls disproportionately on underinsured patients, who are least likely to be able to afford it.

Because the final Achieving Healthcare Efficiency through Accountable Design ("AHEAD") model terms had not yet been released, the HSCRC temporarily paused its evaluation of:

- Potential alternatives to current outpatient facility fee billing practices.
- How those alternatives might interact with Maryland's Total Cost of Care obligations under the AHEAD model, including any implications for Medicare total cost-of-care savings if outpatient facility fees were reduced or eliminated.
- The effects of alternative approaches on Medicaid, Medicare, and commercial insurance—particularly the impact on consumer out-of-pocket spending, with a focus on high-deductible commercial plans.

We encourage the HSCRC to resume the study and complete its evaluation so that solutions that better protect consumers from unexpected and escalating facility fee charges can be identified.

¹⁴ [https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/SB1103Ch142\(2\)\(2024\)_2024.pdf](https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/SB1103Ch142(2)(2024)_2024.pdf) (last accessed September 22, 2026).

HEAU Facility Fee Related Complaints

Consumer complaints filed with our office this reporting period offer the consumer's perspective regarding these types of surprise bills.

- a. A consumer scheduled her annual physical, expecting it to be fully covered with no out-of-pocket cost. During the appointment, her provider briefly discussed a separate health issue – the need for a thyroid evaluation – and added a diagnostic code to the claim. This resulted in an unexpected \$200 facility fee and other charges. Even though she received a facility fee notice in advance, she assumed the fee would not apply to a routine, no-cost preventive visit. Preventive services are designed to remove cost barriers, and applying facility fees because a provider addressed an additional concern during an annual exam runs counter to that goal.
- b. A consumer underwent a cardiac catheter procedure at a Maryland hospital. After the procedure, the hospital's cardiac rehabilitation center contacted him and informed him that he was eligible for its cardiac rehab program and that the services would be fully covered by his insurance. He later received hospital bills totaling more than \$1,700.

Under his insurance policy, members owe a \$35 copayment per visit when receiving cardiac rehabilitation services from an in-network preferred provider, as was the case here, *but only if* the services were not rendered in the outpatient department of a hospital, hospital clinic, or a provider's office located within a hospital or hospital clinic with a separate facility claim. When services are provided in those settings and billed separately, the members' claims are instead subject to their in-network deductible, which in this case was \$9,200. This case highlights how quickly out-of-pocket costs can escalate when facility billing rules apply, even when consumers believe their care is fully covered.

- c. A consumer reported suffering from severe daily migraines that required quarterly Botox injections. She explained that she had to change neurologists because her hospital-based provider would only administer the injections in a hospital setting, resulting in a facility fee she had trouble affording. She shared that "as a result of this quarterly site-of-service change... I and my insurance are being charged \$6,518.25 in unnecessary dollars multiple times a year. I end up being responsible for about \$1,500 each quarter after insurance." After years of "this financial abuse," she transitioned her neurologist and most of her care away from the hospital. She now pays \$30 for the Botox medication and a \$50 copay for the physician visit—\$80 instead of \$1,500. This complaint underscores how differences in site-of-service billing can significantly affect affordability and access to essential medical treatment.

2. Other Out-of-Network Facilities

The HEAU continues to receive complaints from consumers who, after being referred by an in-network provider to an out-of-network facility, including facilities owned or operated by, or otherwise financially affiliated with, the referring provider, unknowingly receive services at out-of-network locations. As a result of such referrals, consumers incur charges substantially higher than those that would have applied had the services been rendered at an in-network facility.

The HEAU has determined that numerous out-of-network facilities fail to provide any notice of their out-of-network status, while others present consumers with forms stating only that the facility *may* be out-of-network. Such forms are frequently included among numerous documents presented at the time of service, thereby depriving consumers of a meaningful opportunity to review, understand, or modify them. Accordingly, these practices impede consumers' ability to make informed decisions about where to obtain care and expose them to unexpected and excessive financial liability.

Although the federal No Surprises Act is expected to address these concerns through implementation of the Good Faith Estimate and Advanced Explanation of Benefits provisions, the regulatory process remains incomplete, and the timing of full implementation is uncertain. Further, although the Maryland Consumer Protection Act prohibits providers from withholding material price information, the HEAU recommends that the General Assembly enact additional statutory protections to safeguard Maryland consumers. At a minimum, legislation should require that out-of-network facilities provide a pre-appointment, stand-alone notice disclosing their out-of-network status and a detailed, written cost estimate for all planned services. These disclosures shall be presented separately from other intake documents and in a manner that affords consumers a meaningful opportunity to review and understand the financial implications of receiving care at an out-of-network facility.

3. Financing Products for Medical Expenses

During the 2025 legislative session, the General Assembly enacted significant protections to reduce the impact of medical debt on Maryland residents. 2025 Laws of Maryland, Chapter 498 (HB 428) protects a consumer's primary residence from forced sale due to medical debt, and 2025 Laws of Maryland, Chapter 121 (HB 1020) restricts the reporting of certain medical debt on credit reports – both measures intended to mitigate the risks of foreclosure and long-term credit harm for individuals seeking necessary medical care.

Despite these important advances, substantial consumer-protection gaps persist. The HEAU continues to observe increasing reliance on medical credit cards and financing products offered at the point of care, often when patients are in pain or facing urgent clinical decisions, conditions that undermine informed consent and heighten financial vulnerability. A 2025 JAMA analysis¹⁵ documents a sharp rise in the promotion of medical credit cards such as Alphaeon, CareCredit, and Wells Fargo Health Advantage across multiple specialties, frequently without adequate explanation of the financial risks involved.

Federal regulators have similarly warned of widespread consumer harm. The Consumer Financial Protection Bureau's report on medical credit cards and financing plans¹⁶ found that consumers paid over \$1 billion in deferred interest between 2018 and 2020, with more than 17 million medical purchases financed under high-risk terms during that period. Lower-income and

¹⁵ Joseph Dov Bruch, Cal Chengqi Fang & Betsy Q. Cliff, *Prevalence of Medical Credit Cards by Specialty*, JAMA Health Forum (Apr. 11, 2025), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2832438>, doi:10.1001/jamahealthforum.2025.0174 (last accessed September 23, 2026).

¹⁶ Consumer Financial Protection Bureau, *Medical Credit Cards and Financing Plans* (May 4, 2023), <https://www.consumerfinance.gov/data-research/research-reports/medical-credit-cards-and-financing-plans/> (last accessed September 23, 2026).

lower-credit-score consumers were disproportionately affected, incurring interest charges more frequently and facing shorter deferment windows before retroactive interest was imposed.

Consistent with national findings, the HEAU continues to receive complaints from consumers who unknowingly incur high-interest or deferred-interest medical debt. In many cases, providers receive full payment upfront from the lender, including for services not yet rendered, while consumers are issued financing products they did not fully understand. These arrangements place patients at risk of:

- **Paying for services not received or performed inadequately**, particularly when providers require non-refundable upfront payment;
- **Waiving insurance protections**, including those available under the No Surprises Act, by financing care before insurers adjudicate claims; and
- **Losing access to financial assistance or charity care**, which may otherwise reduce or eliminate out-of-pocket costs.

HEAU Medical Financing Related Complaints

The complaint summaries below, and many more like them included in the HEAU's FY 2025 Annual Report, are a glimpse into the types of complaints the HEAU has handled regarding these types of financing products.

- a. A consumer sought treatment at a dental practice to have her remaining teeth removed and begin the process of being fitted for permanent dentures. After examination, she was presented with a \$7,738 treatment plan. Following insurance payments and adjustments, the provider informed her that her out-of-pocket responsibility would be \$4,555. She was then given an application for third-party financing for that amount, which was immediately approved and paid directly to the provider.

After the extractions, the consumer received temporary dentures, which did not fit properly. She was told this was due to swelling and that her permanent dentures would "fit like a glove." However, when the permanent dentures were delivered, the bottom denture repeatedly lifted, and the top denture was so loose that it caused whistling when she spoke. Multiple follow-up visits failed to resolve the issues, leaving her with dentures she could not use. At the same time, despite setting up autopayments, the bank reported her payments as late, added a monthly fee for paper statements she did not request and increased her interest rate due to the alleged late payments, causing her loan payments to rise even though she was making consistent monthly autopayments.

The consumer continued making payments and attempted for weeks to obtain a refund for services that failed to meet the promised standard. Unable to resolve the matter on her own, she contacted our office for assistance. The HEAU intervened, resulting in the complete elimination of the \$4,555 credit line and a refund of \$1,159.39 in payments she had already made. This resolution allowed the consumer to pursue appropriate dental care elsewhere.

- b. A consumer seeking orthodontic treatment purchased aligners from a telehealth dental company in November 2023 and began treatment in January 2024. The company offered financing, and the consumer obtained a \$2,149 installment loan through a third-party lender for 36 months at a 26.99% APR, approved on November 30, 2023. On that same day, the lender issued payment for the full loan amount upfront directly to the telehealth provider, before any services had begun. Monthly loan payments began in January 2024.

By March 2024, the consumer had completed treatment for the upper arch and continued treatment for the lower arch, which was ineffective. On April 3, 2025, the company's clinical support team notified her that the prescribing dentist recommended discontinuing treatment and advised her to seek in-person care with a local dentist. The communication stated the consumer would receive a refund. Despite this assurance, the consumer received no refund, leaving her with incomplete treatment and a high-interest loan.

The consumer repeatedly requested a refund for the lower arch treatment that was never completed. The company responded with generic, circular emails that redirected her to contacts she had already tried and refused to provide the name of her treating provider, stating that the information was unavailable. Better Business Bureau (BBB) intervention was unsuccessful.

Our office contacted both the dental provider and the financing company, ultimately securing \$1,754.40 in refunds and credits, enabling the consumer to seek appropriate orthodontic care elsewhere.

- c. A consumer had an emergency visit at a dental office on September 15, 2025. After the examination, she was provided with a \$6,034 treatment plan, and financing options were discussed. However, without her knowledge or consent, the dental office proceeded to arrange third-party financing for the full amount. The financing company immediately paid the provider, even though the consumer had neither agreed to the loan nor authorized the transaction.

The consumer was scheduled to begin treatment two days later but called the next day to cancel, stating she could not proceed "due to the high cost of the proposed treatment." Despite canceling before any services were rendered, the provider had already accepted payment through the unauthorized loan.

Two weeks later, the consumer received her first bill from the financing company and learned for the first time that a loan had been opened in her name. She disputed the charges immediately, stating: "This billing is a serious error and constitutes an unlawful attempt to collect payment for services that were never rendered." She contacted both the dental office and the financing company, but each referred her back to the other.

Billing notices continued month after month, and the consumer began receiving late fees of \$30 per month and paper statement fees of \$2.99, adding financial pressure to an already distressing situation. The consumer remained stuck with a loan she never authorized, for treatment she never received, and no clear path to correction.

After months of unsuccessful attempts to resolve the issue directly, the consumer contacted our office. We intervened and secured a full waiver of the debt, relieving the consumer of an improperly initiated loan and ensuring she would not be held responsible for charges she never agreed to.

These cases demonstrate the significant risks that come with financing medical services and underscore the need for Maryland to close existing gaps in its medical debt protections. State laws must ensure that all health care-related financing is subject to enforceable consumer safeguards. Absent legislative action, more Marylanders will incur escalating, high-cost medical debt that undermines access to affordable, necessary care. With federal oversight uncertain and the Consumer Financial Protection Bureau reducing its medical debt enforcement priorities, strong state-level protections have become urgent.

The National Consumer Law Center's June 2026 Issue Brief, *What States Can Do: Medical Credit Cards and Other Medical Lending Products*,¹⁷ provides examples of measures adopted in other jurisdictions to protect consumers from predatory medical financing practices.

Based on these considerations, the HEAU recommends that Maryland adopt, at a minimum, the following protections:

- Prohibit providers and their staff from completing third-party credit applications on behalf of patients.
- Prohibit providers and their staff from supplying electronic devices or digital platforms for patients to apply for financing.
- Prohibit the promotion, advertisement, or marketing of financing products in treatment rooms or during any period in which a patient is undergoing treatment, including when a patient is under general anesthesia, conscious sedation, or nitrous oxide.
- Prohibit providers from charging treatment or related costs to a financing product prior to the date the treatment is rendered or costs are incurred.
- Prohibit providers from charging treatment or costs to a financing product when such charges are barred by Medicaid, Medicare, private insurance contracts, balance billing prohibitions, or the federal No Surprises Act.
- Prohibit providers from charging treatment or costs to a financing product when those charges could otherwise qualify for hospital financial assistance or income-based payment plan protections.
- Require providers to inform patients—each time a financing product is used—of any foreclosure protections, credit-reporting safeguards, or other consumer rights that do not apply when using that product.

These reforms would help ensure that Maryland residents are not subjected to harmful, high-interest medical credit arrangements and would align Maryland with emerging national best practices. With federal agencies no longer pursuing meaningful oversight in this area, the responsibility, and opportunity, now falls to the Maryland General Assembly to safeguard Marylanders from predatory and discriminatory healthcare financing practices.

¹⁷ National Consumer Law Center, *What States Can Do: Medical Credit Cards and Other Medical Lending Products*, <https://www.nclc.org/resources/what-states-can-do-medical-credit-cards-and-other-medical-lending-products/> (last accessed September 23, 2026).

4. Additional Concerns

The HEAU also has concerns about providers who (a) require pre-treatment payments of deductibles and coinsurance; (b) fail to refund overpayments; (c) fail to provide reasonable refund policies for canceled appointments; (d) refuse to provide service without obtaining a credit card “on file” with authority to charge unspecified amounts; (e) fail to provide requested medical records; (f) submit claims with incorrect diagnostic codes that result in greater patient cost-sharing; (g) abandon medical records; and (h) charge insured patients administrative fees for services integral to the provision of health care.

VII. Conclusion

The Maryland General Assembly continues to advance measures that strengthen consumer protections and curb abusive practices in the health care marketplace, notwithstanding opposition from stakeholders seeking to prioritize financial interests. The HEAU remains committed to working collaboratively with policymakers and industry leaders to promote a health care system that delivers timely, transparent, affordable, and high-quality care for all Marylanders.

Appendix

**Carrier Cases
Adverse Decisions, Grievances and Outcomes**

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Aetna Dental Inc.	44	0	0	0%	0%
Aetna Health Inc. (a Pennsylvania corporation)	2,281	7	206	67%	33%
Aetna Life Insurance Company	4,127	12	272	68%	32%
Alpha Dental Programs, Inc.	36	0	3	100%	0%
Ameritas Life Insurance Corp.	929	0	415	58%	42%
BCS Insurance Company*	0	0	2	100%	0%
CareFirst BlueChoice, Inc.	42,358	0	4,322	47%	53%
Carefirst of Maryland, Inc.	14,772	0	1,854	40%	60%
CIGNA Health and Life Insurance Company	24,004	0	715	51%	49%
Colonial Life & Accident Insurance Company	28	0	0	0%	0%
Delta Dental Insurance Company	454	4	1	100%	0%
Delta Dental of Pennsylvania	1,671	10	22	45%	55%
Dental Network, Inc.*	3	0	3	0%	100%
Dentegra Insurance Company	162	3	2	50%	50%
Dominion Dental Services, Inc.	1,656	0	45	60%	40%
Equitable Financial Life Insurance Company of America*	2	0	1	100%	0%
Golden Rule Insurance Company	38	0	3	67%	33%
Group Hospitalization and Medical Services, Inc.	11,719	0	1,367	50%	50%
Guarantee Trust Life Insurance Company	1	1	1	0%	100%
Guardian Life Insurance Company of America	1,269	0	708	53%	47%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overturned/ Modified
Independence American Insurance Company*	0	0	1	100%	0%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	3,415	0	197	59%	41%
Kaiser Permanente Insurance Company	7	0	2	50%	50%
Lincoln Life & Annuity Company of New York*	2	0	0	0%	0%
Lincoln National Life Insurance Company	142	38	0	0%	0%
MAMSI Life and Health Insurance Company	718	0	101	42%	58%
Metropolitan Life Insurance Company	241	62	21	33%	67%
Mutual of Omaha Insurance Company	28	0	0	0%	0%
National Health Insurance Company*	1	0	0	0%	0%
Nippon Life Insurance Company of America*	13	0	0	0%	0%
Optimum Choice, Inc.	4,301	0	848	37%	63%
Principal Life Insurance Company	1,034	0	75	84%	16%
Reliance Standard Life Insurance Company	113	0	14	57%	43%
Standard Insurance Company	490	0	98	61%	39%
Starmount Life Insurance Company	230	0	12	92%	8%
Sun Life Assurance Company of Canada	12,294	43	58	60%	40%
United Concordia Insurance Company	275	0	95	57%	43%
United of Omaha Life Insurance Company	411	0	4	75%	25%
United States Fire Insurance Company*	40	0	0	0%	0%
UnitedHealthcare Insurance Company	13,503	0	1,050	45%	55%
UnitedHealthcare of the Mid-Atlantic, Inc.	323	0	48	56%	44%

Carrier	Adverse Decisions		Grievances Filed & Outcome		
	Total Adverse Decisions	Carrier Admin. Reversed	Total Grievances	Upheld	Overtured/ Modified
Wellfleet Group LLC	668	3	80	60%	40%
Wellfleet Insurance Company	184	2	54	59%	41%
Wellpoint Maryland, Inc.	545	37	21	81%	19%
Totals	144,532	222	12,721	48%	52%

* Indicates possible, but not verified, anomalies in the data reporting.

**Carrier Cases
Denial Rate of Clean Claims**

Carriers must report enrollee numbers and the number of clean claims. The table below shows that data and the denial rate of medical necessity denials in relation to clean claims, which excludes coverage denials, and denials for administrative issues, coding errors, and other non-specified reasons.

Carrier	Total Enrolled (Avg)	Total Clean Claims	Total Adverse Decisions	Denial Rate
Aetna Dental Inc.	5,222	5,816	44	0.76%
Aetna Health Inc. (a Pennsylvania corporation)	2,428	122,742	2,281	1.86%
Aetna Life Insurance Company	34,069	385,637	4,127	1.07%
Alpha Dental Programs, Inc.	20,634	9,621	36	0.37%
Ameritas Life Insurance Corp.	14,423	14,254	929	6.52%
BCS Insurance Company*	1,533	81	0	0.00%
CareFirst BlueChoice, Inc.	420,947	9,891,740	42,358	0.43%
Carefirst of Maryland, Inc.	33,999	970,712	14,772	1.52%
CIGNA Health and Life Insurance Company	163,023	637,015	24,004	3.77%
Colonial Life & Accident Insurance Company	1,462	1,378	28	2.03%
Delta Dental Insurance Company	16,915	53,785	454	0.84%
Delta Dental of Pennsylvania	178,099	369,029	1,671	0.45%
Dental Network, Inc.*	0	0	3	N/A
Dentegra Insurance Company	17,096	21,178	162	0.76%
Dominion Dental Services, Inc.	9,541	30,555	1,656	5.42%
Equitable Financial Life Insurance Company of America*	12,170	1,135	2	0.18%
Golden Rule Insurance Company	16,535	13,086	38	0.29%
Group Hospitalization and Medical Services, Inc.	27,764	839,393	11,719	1.40%

Carrier	Total Enrolled (Avg)	Total Clean Claims	Total Adverse Decisions	Denial Rate
Guarantee Trust Life Insurance Company*	3,976	5,381	1	0.02%
Guardian Life Insurance Company of America	42,865	122,365	1,269	1.04%
Independence American Insurance Company*	428	447	0	0.00%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	179,815	2,198,700	3,415	0.16%
Kaiser Permanente Insurance Company	5,857	5,279	7	0.13%
Lincoln Life & Annuity Company of New York*	8,394	2,835	2	0.07%
Lincoln National Life Insurance Company*	7,340	11,241	142	1.26%
MAMSI Life and Health Insurance Company	15,645	102,333	718	0.70%
Metropolitan Life Insurance Company*	0	0	241	N/A
Mutual of Omaha Insurance Company	7,245	13,336	28	0.21%
National Health Insurance Company*	161	532	1	0.19%
Nippon Life Insurance Company of America*	346	238	13	5.46%
Optimum Choice, Inc.	285,161	196,557	4,301	2.19%
Principal Life Insurance Company	29,462	131,184	1,034	0.79%
Reliance Standard Life Insurance Company	518	1,168	113	9.67%
Standard Insurance Company	2,253	8,838	490	5.54%
Starmount Life Insurance Company	6,904	8,850	230	2.60%
Sun Life Assurance Company of Canada	21,393	34,178	12,294	35.97%
United Concordia Insurance Company	181,414	33,105	275	0.83%
United of Omaha Life Insurance Company	5,870	10,395	411	3.95%
United States Fire Insurance Company	10,709	4,746	40	0.84%

Carrier	Total Enrolled (Avg)	Total Clean Claims	Total Adverse Decisions	Denial Rate
UnitedHealthcare Insurance Company	267,821	650,244	13,503	2.08%
UnitedHealthcare of the Mid-Atlantic, Inc.	10,785	34,526	323	0.94%
Wellfleet Group LLC	15,687	164,923	668	0.41%
Wellfleet Insurance Company	1,625	32,540	184	0.57%
Wellpoint Maryland, Inc.	2,319	38,071	545	1.43%

* Indicates possible, but not verified, anomalies in the data reporting.

**Carrier Cases
Adverse Decisions Regarding Prior Authorization**

Carriers must report whether an adverse decision involved a prior authorization request. The table below shows the percentage of adverse decisions that were associated with prior authorization, as reported by carriers. Values reported as zero may indicate either that no prior authorization requests occurred or that the carrier did not provide the required information.

Carrier	Total Adverse Decisions	Total Prior Authorization	Adverse Decisions Rate
Aetna Dental Inc.	44	0	0.00%
Aetna Health Inc. (a Pennsylvania corporation)	2,281	740	32.44%
Aetna Life Insurance Company	4,127	1,925	46.64%
Alpha Dental Programs, Inc.	36	6	16.67%
Ameritas Life Insurance Corp.	929	0	0.00%
BCS Insurance Company	0	0	0.00%
CareFirst BlueChoice, Inc.	42,358	32,289	76.23%
Carefirst of Maryland, Inc.	14,772	13,914	94.19%
CIGNA Health and Life Insurance Company	24,004	113	0.47%
Colonial Life & Accident Insurance Company	28	0	0.00%
Delta Dental Insurance Company	454	115	25.33%
Delta Dental of Pennsylvania	1,671	546	32.68%
Dental Network, Inc.	3	0	0.00%
Dentegra Insurance Company	162	89	54.94%
Dominion Dental Services, Inc.	1,656	0	0.00%
Equitable Financial Life Insurance Company of America	2	0	0.00%
Golden Rule Insurance Company	38	9	23.68%
Group Hospitalization and Medical Services, Inc.	11,719	9,600	81.92%
Guarantee Trust Life Insurance Company	1	0	0.00%
Guardian Life Insurance Company of America	1,269	0	0.00%
Independence American Insurance Company	0	0	0.00%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	3,415	3,008	88.08%

Carrier	Total Adverse Decisions	Total Prior Authorization	Adverse Decisions Rate
Kaiser Permanente Insurance Company	7	0	0.00%
Lincoln Life & Annuity Company of New York	2	0	0.00%
Lincoln National Life Insurance Company	142	0	0.00%
MAMSI Life and Health Insurance Company	718	282	39.28%
Metropolitan Life Insurance Company	241	0	0.00%
Mutual of Omaha Insurance Company	28	0	0.00%
National Health Insurance Company	1	0	0.00%
Nippon Life Insurance Company of America	13	0	0.00%
Optimum Choice, Inc.	4,301	1,918	44.59%
Principal Life Insurance Company	1,034	0	0.00%
Reliance Standard Life Insurance Company	113	0	0.00%
Standard Insurance Company	490	0	0.00%
Starmount Life Insurance Company	230	0	0.00%
Sun Life Assurance Company of Canada	12,294	0	0.00%
United Concordia Insurance Company	275	0	0.00%
United of Omaha Life Insurance Company	411	0	0.00%
United States Fire Insurance Company	40	0	0.00%
UnitedHealthcare Insurance Company	13,503	2,976	22.04%
UnitedHealthcare of the Mid-Atlantic, Inc.	323	75	23.22%
Wellfleet Group LLC	668	315	47.16%
Wellfleet Insurance Company	184	76	41.30%
Wellpoint Maryland, Inc.	545	311	57.06%
Totals	144,532	68,307	47.26%

**Carrier Cases
Adverse Decisions Regarding Step Therapy**

Carriers must report whether an adverse decision involved step therapy protocol. The table below shows the percentage of adverse decisions that were associated with step therapy protocol, as reported by carriers. Values reported as zero may indicate either that no step therapy requirements occurred or that the carrier did not provide the required information.

Carrier	Total Adverse Decisions	Total Step Therapy	Adverse Decisions Rate
Aetna Dental Inc.	44	0	0.00%
Aetna Health Inc. (a Pennsylvania corporation)	2,281	11	0.48%
Aetna Life Insurance Company	4,127	11	0.27%
Alpha Dental Programs, Inc.	36	0	0.00%
Ameritas Life Insurance Corp.	929	0	0.00%
BCS Insurance Company	0	0	0.00%
CareFirst BlueChoice, Inc.	42,358	166	0.39%
Carefirst of Maryland, Inc.	14,772	191	1.29%
CIGNA Health and Life Insurance Company	24,004	0	0.00%
Colonial Life & Accident Insurance Company	28	0	0.00%
Delta Dental Insurance Company	454	0	0.00%
Delta Dental of Pennsylvania	1,671	0	0.00%
Dental Network, Inc.	3	0	0.00%
Dentegra Insurance Company	162	0	0.00%
Dominion Dental Services, Inc.	1,656	0	0.00%
Equitable Financial Life Insurance Company of America	2	0	0.00%
Golden Rule Insurance Company	38	4	10.53%
Group Hospitalization and Medical Services, Inc.	11,719	125	1.07%
Guarantee Trust Life Insurance Company	1	0	0.00%
Guardian Life Insurance Company of America	1,269	0	0.00%
Independence American Insurance Company	0	0	0.00%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	3,415	0	0.00%

Carrier	Total Adverse Decisions	Total Step Therapy	Adverse Decisions Rate
Kaiser Permanente Insurance Company	7	0	0.00%
Lincoln Life & Annuity Company of New York	2	0	0.00%
Lincoln National Life Insurance Company	142	0	0.00%
MAMSI Life and Health Insurance Company	718	16	2.23%
Metropolitan Life Insurance Company	241	0	0.00%
Mutual of Omaha Insurance Company	28	0	0.00%
National Health Insurance Company	1	0	0.00%
Nippon Life Insurance Company of America	13	0	0.00%
Optimum Choice, Inc.	4,301	36	0.84%
Principal Life Insurance Company	1,034	0	0.00%
Reliance Standard Life Insurance Company	113	0	0.00%
Standard Insurance Company	490	0	0.00%
Starmount Life Insurance Company	230	0	0.00%
Sun Life Assurance Company of Canada	12,294	0	0.00%
United Concordia Insurance Company	275	0	0.00%
United of Omaha Life Insurance Company	411	0	0.00%
United States Fire Insurance Company	40	0	0.00%
UnitedHealthcare Insurance Company	13,503	205	1.52%
UnitedHealthcare of the Mid-Atlantic, Inc.	323	1	0.31%
Wellfleet Group LLC	668	53	7.93%
Wellfleet Insurance Company	184	6	3.26%
Wellpoint Maryland, Inc.	545	175	32.11%
Totals	144,532	1,000	0.69%

Carrier Cases
Denial Rate of Non-Formulary Requests

Carriers must report the number of requests made for a non-formulary drug and the outcome of those requests. The table below shows the carrier reported data. Values reported as zero may indicate either that no non-formulary drug requests occurred or that the carrier did not provide the required information.

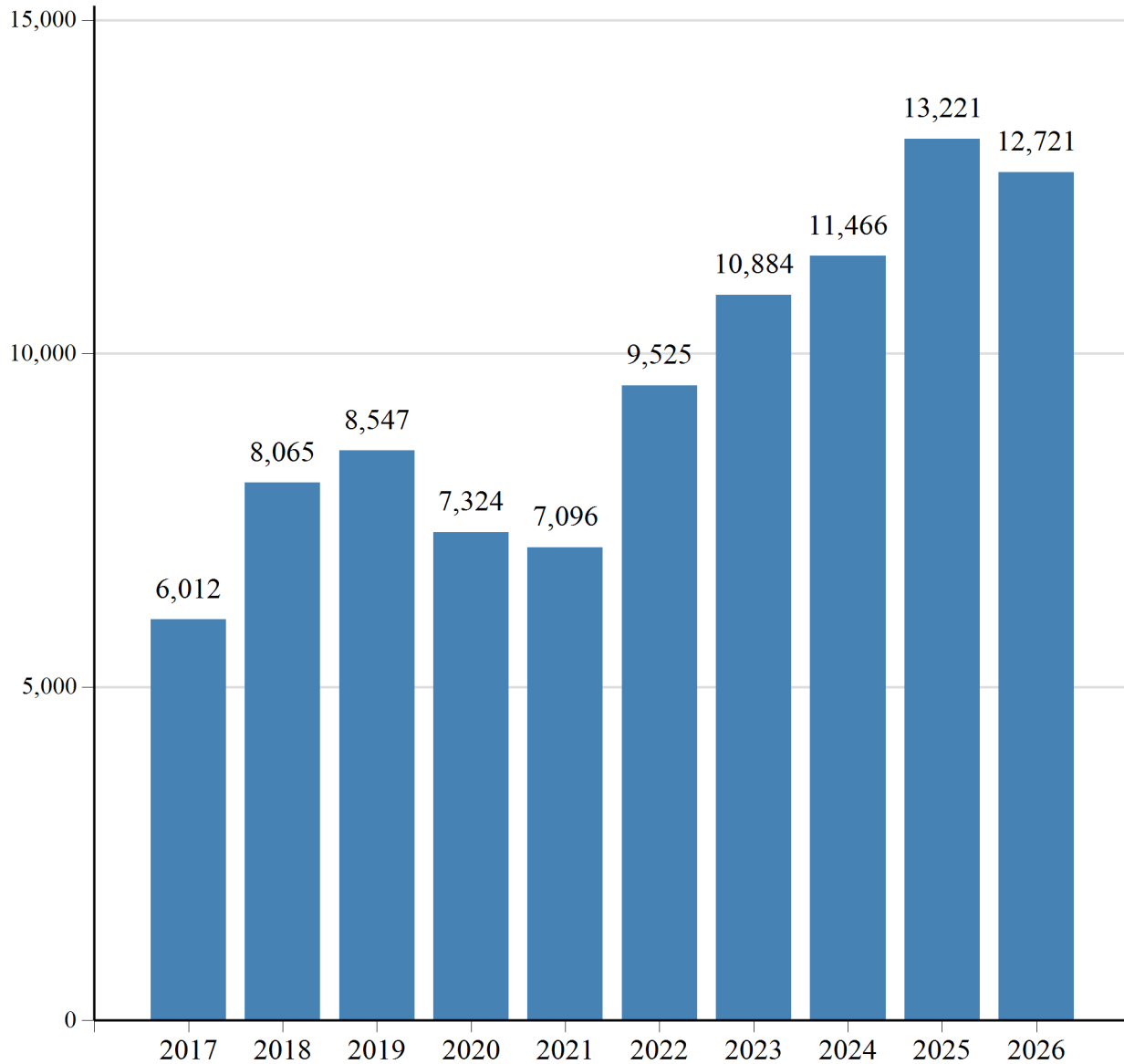
Carrier	Total Requests Made	Total Requests Granted	Denial Rate
Aetna Dental Inc.	0	0	0.00%
Aetna Health Inc. (a Pennsylvania corporation)	388	78	79.90%
Aetna Life Insurance Company	433	109	74.83%
Alpha Dental Programs, Inc.	0	0	0.00%
Ameritas Life Insurance Corp.	0	0	0.00%
BCS Insurance Company	0	0	0.00%
CareFirst BlueChoice, Inc.	13,912	5,059	63.64%
Carefirst of Maryland, Inc.	9,157	3,845	58.01%
CIGNA Health and Life Insurance Company	0	0	0.00%
Colonial Life & Accident Insurance Company	0	0	0.00%
Delta Dental Insurance Company	0	0	0.00%
Delta Dental of Pennsylvania	0	0	0.00%
Dental Network, Inc.	0	0	0.00%
Dentegra Insurance Company	0	0	0.00%
Dominion Dental Services, Inc.	0	0	0.00%
Equitable Financial Life Insurance Company of America	0	0	0.00%
Golden Rule Insurance Company	11	1	90.91%
Group Hospitalization and Medical Services, Inc.	6,734	2,741	59.30%
Guarantee Trust Life Insurance Company	0	0	0.00%
Guardian Life Insurance Company of America	0	0	0.00%
Independence American Insurance Company	0	0	0.00%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	11,514	10,768	6.48%
Kaiser Permanente Insurance Company	0	0	0.00%

Carrier	Total Requests Made	Total Requests Granted	Denial Rate
Lincoln Life & Annuity Company of New York	0	0	0.00%
Lincoln National Life Insurance Company	0	0	0.00%
MAMSI Life and Health Insurance Company	85	36	57.65%
Metropolitan Life Insurance Company	0	0	0.00%
Mutual of Omaha Insurance Company	0	0	0.00%
National Health Insurance Company	0	0	0.00%
Nippon Life Insurance Company of America	0	0	0.00%
Optimum Choice, Inc.	244	112	54.10%
Principal Life Insurance Company	0	0	0.00%
Reliance Standard Life Insurance Company	0	0	0.00%
Standard Insurance Company	0	0	0.00%
Starmount Life Insurance Company	0	0	0.00%
Sun Life Assurance Company of Canada	0	0	0.00%
United Concordia Insurance Company	0	0	0.00%
United of Omaha Life Insurance Company	0	0	0.00%
United States Fire Insurance Company	0	0	0.00%
UnitedHealthcare Insurance Company	1,130	464	58.94%
UnitedHealthcare of the Mid-Atlantic, Inc.	33	19	42.42%
Wellfleet Group LLC	401	245	38.90%
Wellfleet Insurance Company	72	50	30.56%
Wellpoint Maryland, Inc.	112	86	23.21%
Totals	44,226	23,613	46.61%

Many carriers did not report in Quarter 3 of 2025, so the data is incomplete.

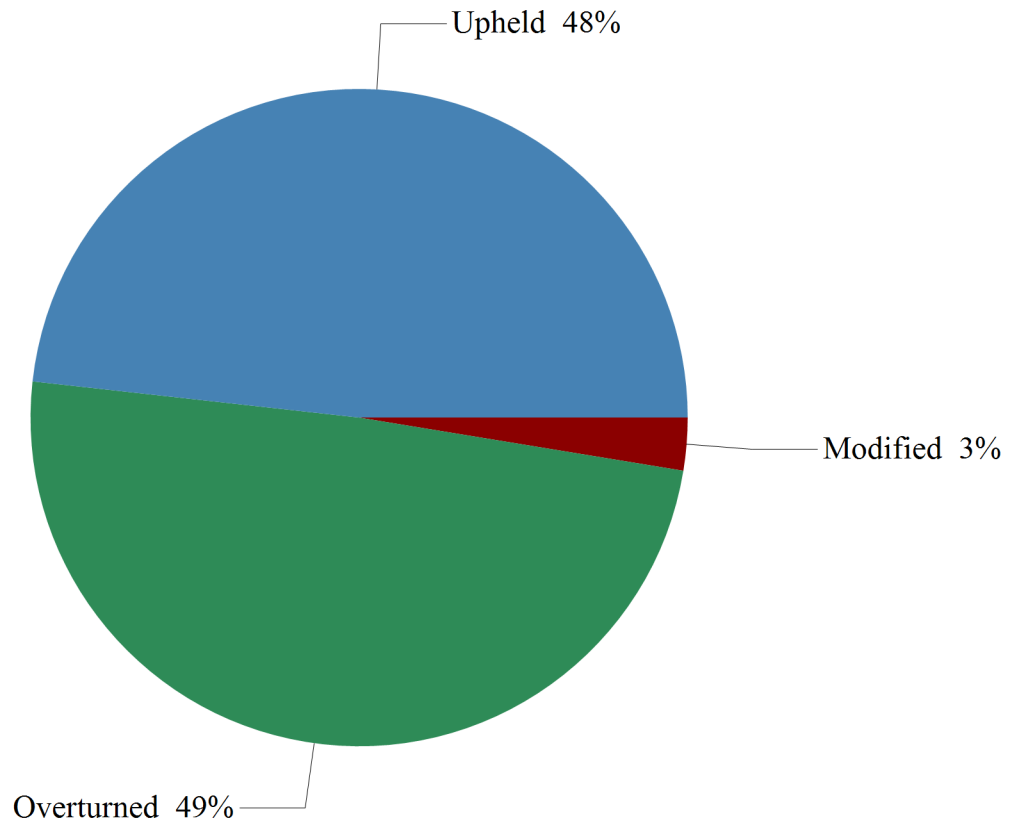
Carrier Grievances Cases Number of Grievances Over 10 Fiscal Years

The chart below shows the history of the number of grievances filed with carriers under the Appeals and Grievances Law over the last 10 fiscal years.



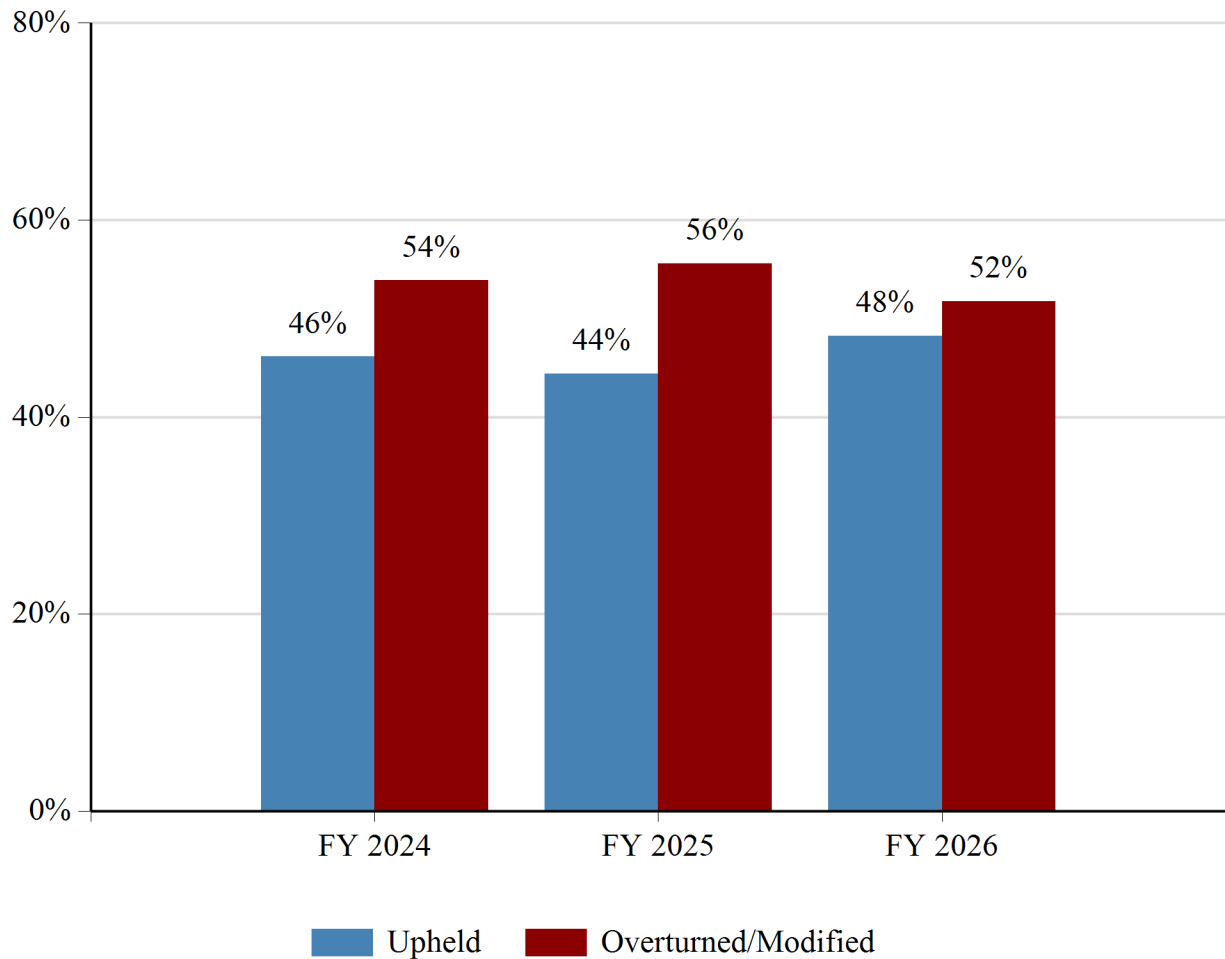
Carrier Grievances Cases Outcomes

The chart below describes the outcomes of the 12,721 internal grievances filed with carriers in FY 2026, as reported by the carriers.



Carrier Grievances Cases Three Year Comparison of Outcomes

The chart below compares the year-to-year outcomes of grievances filed with carriers, as reported by the carriers.



Carrier Grievances Cases Types of Services

Carriers must report the types of services involved in the adverse decisions they issue and the internal grievances they receive. The table below details the types of services involved in the adverse decisions issued and internal grievances filed in FY 2026, as reported by carriers.

Type of Service	Adverse Decisions		Grievances	
Dental	30,548	21.136%	1,909	15.007%
Durable Medical Equipment	1,054	0.729%	102	0.802%
Emergency Room	328	0.227%	32	0.252%
Home Health	295	0.204%	30	0.236%
Inpatient Hospital	3,107	2.150%	153	1.203%
Laboratory, Radiology	32,591	22.549%	2,655	20.871%
Mental Health / Substance Abuse	853	0.590%	118	0.928%
Other*	1,131	0.783%	92	0.723%
Pharmacy	63,281	43.783%	6,451	50.711%
Physician	6,003	4.153%	1,018	8.003%
PT, OT, ST, including inpatient rehabilitation	5,173	3.579%	128	1.006%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	168	0.116%	33	0.259%
Totals	144,532	100%	12,721	100%

*"Other" means obesity, IVF, podiatry, hearing and vision.

Carrier Grievances Cases Outcomes by Service Type

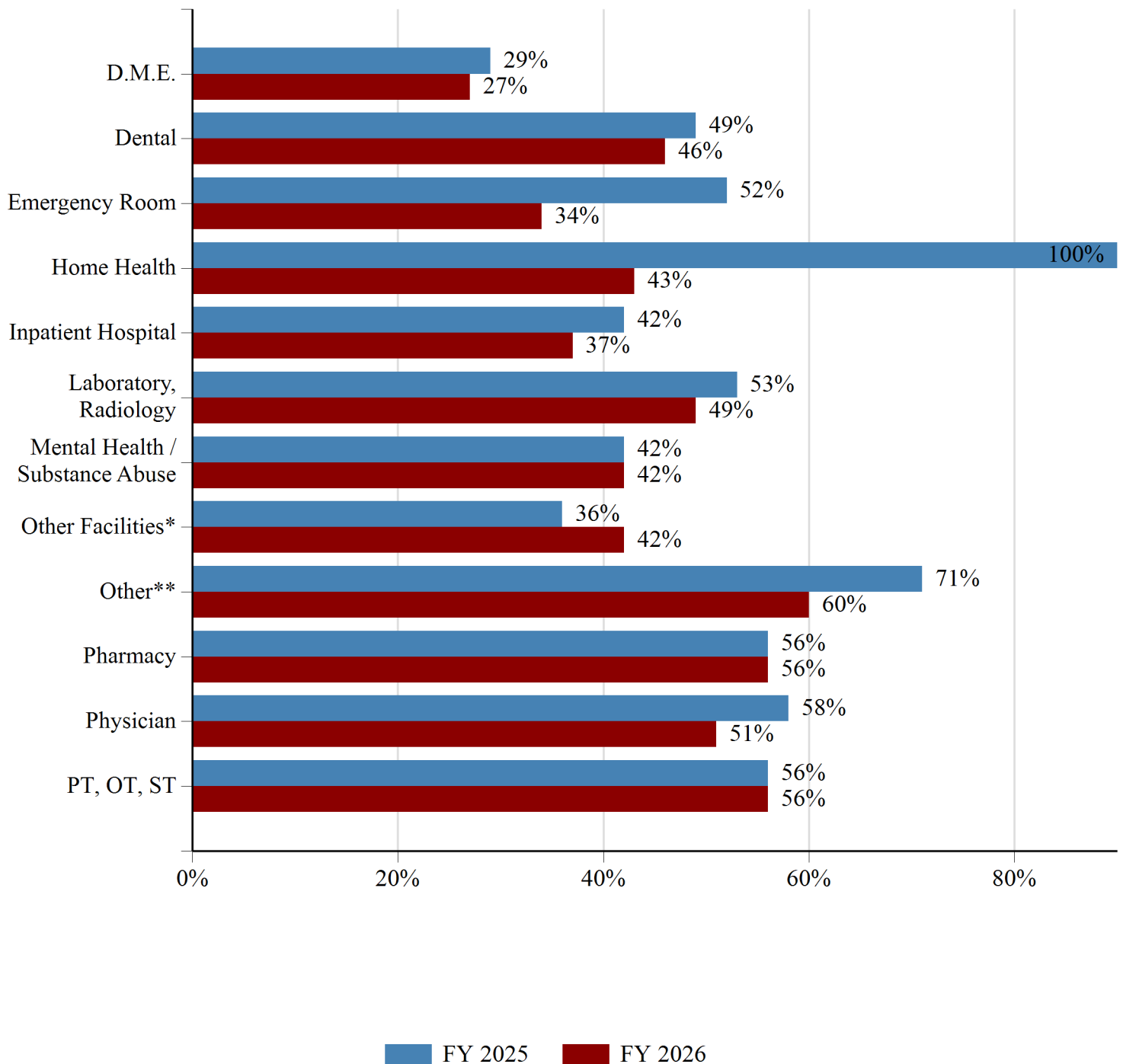
Carriers must identify the types of services involved in the internal grievances they receive and the outcomes of those grievances. The table below compares the variance in the outcomes of grievances based upon the types of services being disputed. The table below is based upon carrier reported data.

Type of Service	Total Grievances	Upheld	Overtured/ Modified
Dental	1,909	54%	46%
Durable Medical Equipment	102	73%	27%
Emergency Room	32	66%	34%
Home Health	30	57%	43%
Inpatient Hospital	153	63%	37%
Laboratory, Radiology	2,655	51%	49%
Mental Health / Substance Abuse	118	58%	42%
Other*	92	40%	60%
Pharmacy	6,451	44%	56%
Physician	1,018	49%	51%
PT, OT, ST, including inpatient rehabilitation	128	44%	56%
Skilled Nursing Facility, Sub Acute Facility, Nursing Home	33	58%	42%
Totals	12,721	48%	52%

*"Other" means obesity, IVF, podiatry, hearing and vision.

Carrier Grievances Cases Two Year Comparison by Service Type

The chart below compares the percentages of grievances carriers overturned or modified by types of services, comparing FY 2025 and FY 2026.



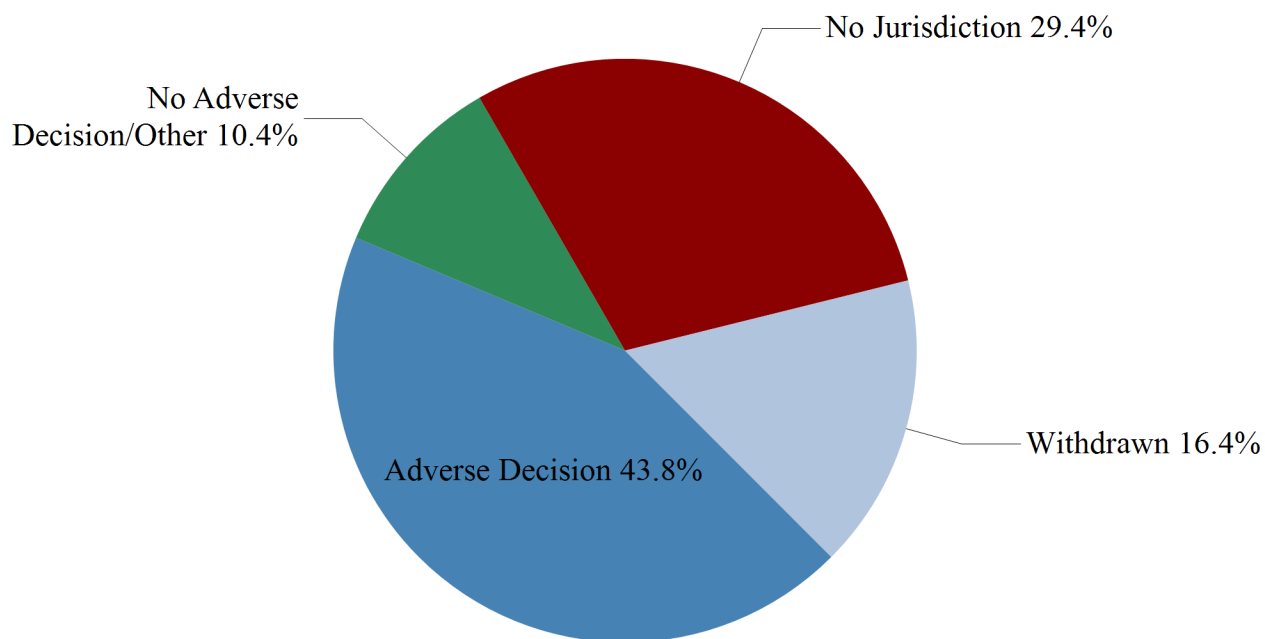
* "Other Facilities" means Skilled Nursing, Sub Acute and Nursing Homes.

** "Other" means obesity, IVF, podiatry, hearing and vision.

MIA Appeals and Grievances Complaints Initial Review of Cases

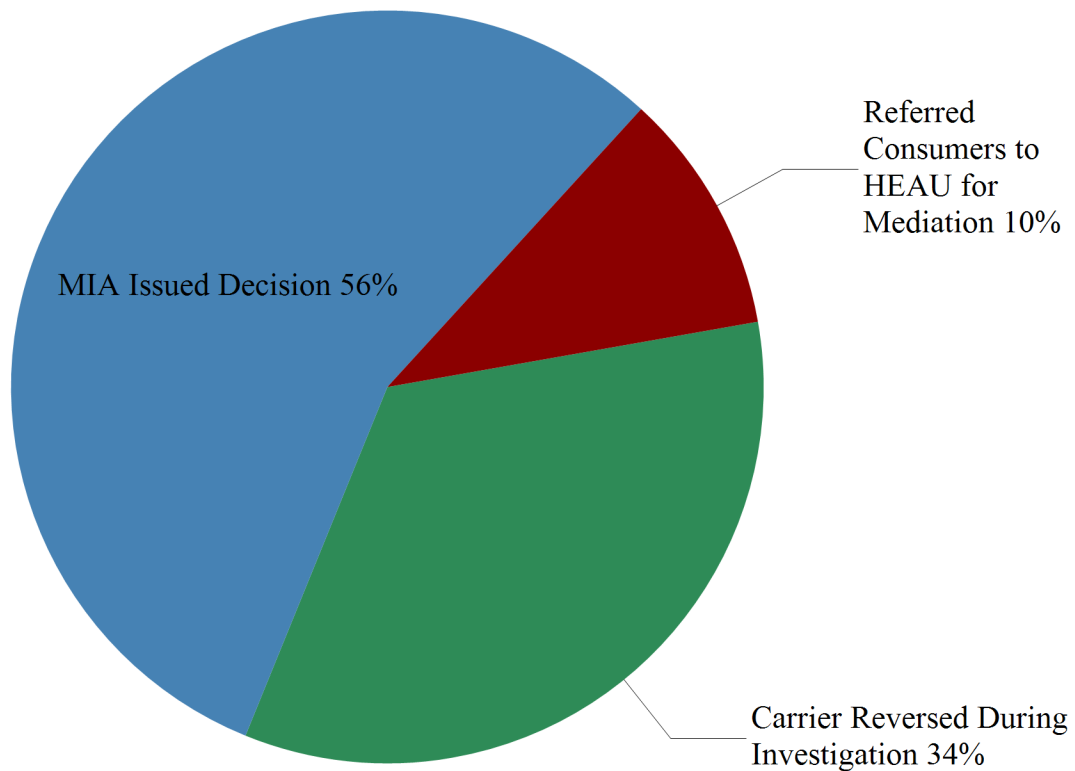
The MIA Appeals and Grievances Unit does not handle all of the complaints it receives. The Unit reviews each complaint to determine if the carrier is subject to State jurisdiction, if the complaint involves an adverse decision, and if the internal grievance process has been exhausted. Moreover, some complaints to the MIA are withdrawn or there is not enough information to complete the review.

The chart below details the initial disposition of the 1,399 cases filed with the MIA's Appeals and Grievances Unit during FY 2026.



MIA Appeals and Grievances Complaints Initial Disposition of Grievances

During FY 2026, the MIA determined that 613 complaints challenged carrier adverse decisions that were subject to state jurisdiction. The MIA referred 64 consumers to the HEAU where the patient had not exhausted the carrier's internal grievance process. The remaining cases resulted in the carriers reversing their decisions or the MIA issuing a decision. The chart below details the initial disposition of the 613 grievances the MIA reviewed during FY 2026.



MIA Appeals and Grievances Cases Carriers and Disposition

The table below details the outcomes of the 549 grievances complaints the MIA investigated during FY 2026. The data, as reported by the MIA, does not include "coverage decisions" (contractual exclusions).

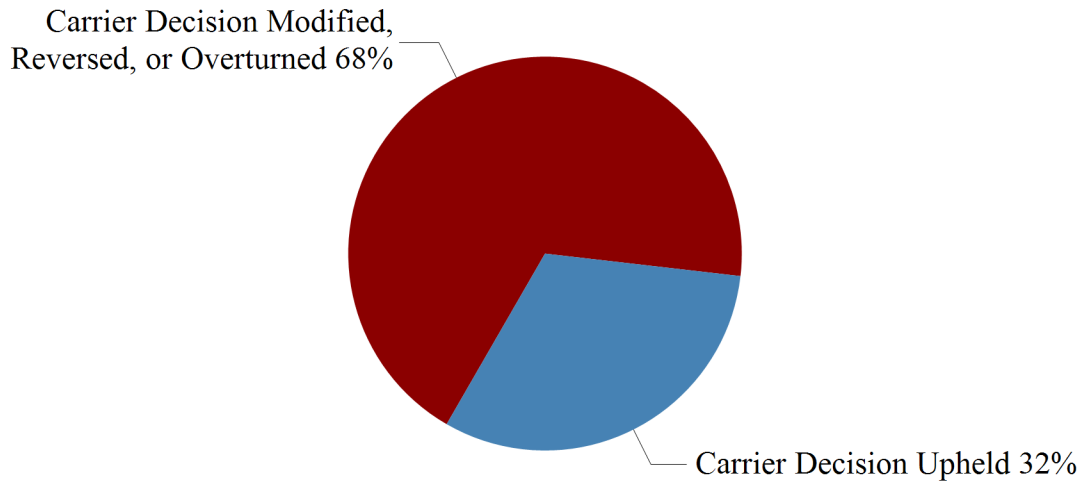
Carrier	Total Grievance Complaints	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Aetna Health Inc. (a Pennsylvania corporation)	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Aetna Health Insurance Company	2	1	50.0%	0	0.0%	0	0.0%	1	50.0%
Aetna Life Insurance Company	3	0	0.0%	1	33.3%	0	0.0%	2	66.7%
Ameritas Life Insurance Corp.	4	2	50.0%	0	0.0%	0	0.0%	2	50.0%
CareFirst BlueChoice, Inc.	205	69	33.7%	64	31.2%	0	0.0%	72	35.1%
Carefirst of Maryland, Inc.	112	39	34.8%	38	33.9%	0	0.0%	35	31.3%
CaremarkPCS Health L.L.C.	3	0	0.0%	0	0.0%	0	0.0%	3	100.0%
CIGNA Health and Life Insurance Company	28	15	53.6%	7	25.0%	0	0.0%	6	21.4%
Delta Dental Insurance Company	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Dominion Dental Services, Inc.	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
Group Hospitalization and Medical Services, Inc.	21	6	28.6%	7	33.3%	0	0.0%	8	38.1%
Guardian Life Insurance Company of America	11	5	45.5%	1	9.1%	1	9.1%	4	36.4%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	12	2	16.7%	6	50.0%	0	0.0%	4	33.3%
MAMSI Life and Health Insurance Company	8	3	37.5%	2	25.0%	0	0.0%	3	37.5%
MedImpact Healthcare Systems, Inc.	58	11	19.0%	13	22.4%	0	0.0%	34	58.6%
Metropolitan Life Insurance Company	6	0	0.0%	0	0.0%	0	0.0%	6	100.0%

Carrier	Total Grievance Complaints	MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Optimum Choice, Inc.	9	2	22.2%	4	44.4%	0	0.0%	3	33.3%
Principal Life Insurance Company	1	1	100.0%	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Insurance Company	61	17	27.9%	20	32.8%	3	4.9%	21	34.4%
Wellpoint Life and Health Insurance Company	2	0	0.0%	1	50.0%	0	0.0%	1	50.0%
Totals	549	173	32%	164	30%	4	1%	208	38%

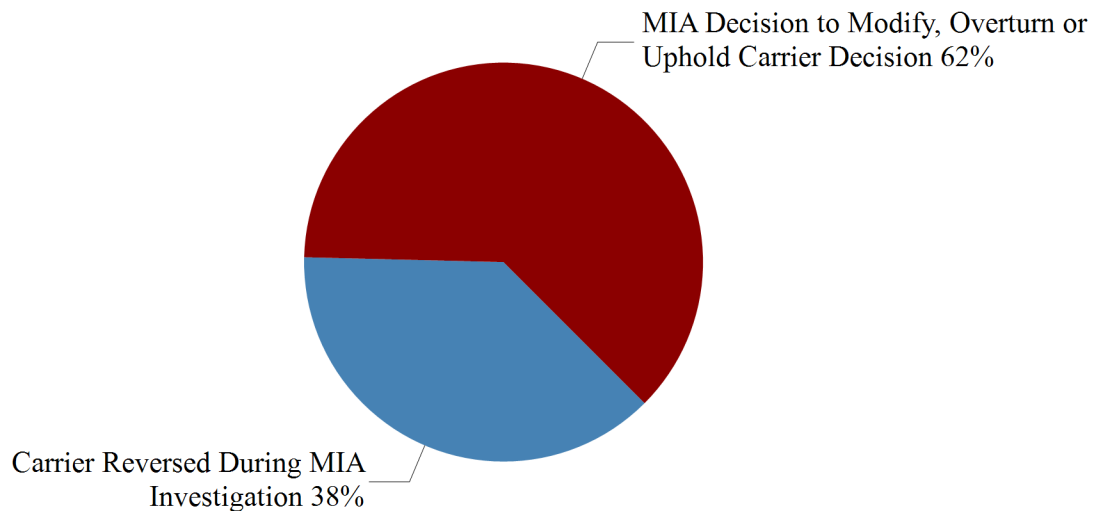
Percentages may not equal 100% due to rounding.

MIA Appeals and Grievances Cases Disposition Following Investigation

The chart below reflects the overall outcomes of the 549 grievances the MIA investigated during FY 2026.

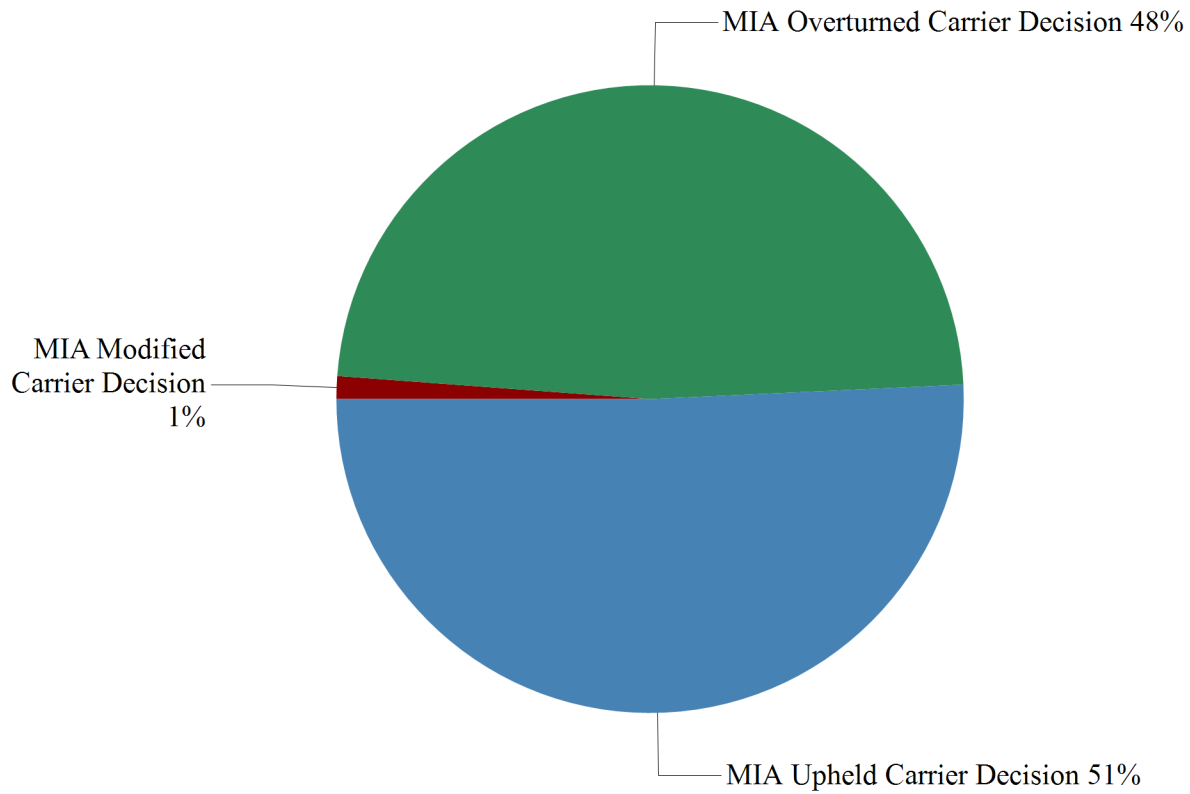


The chart below reflects the percentages of cases reversed by the carrier during the investigative process and those cases that resulted in an MIA decision.



MIA Appeals and Grievances Cases Disposition Resulting from IRO Review

The chart below describes the outcomes of the 341 cases the MIA forwarded to an IRO for review in FY 2026.



MIA Appeals and Grievances Cases Types of Services Denied and Outcomes

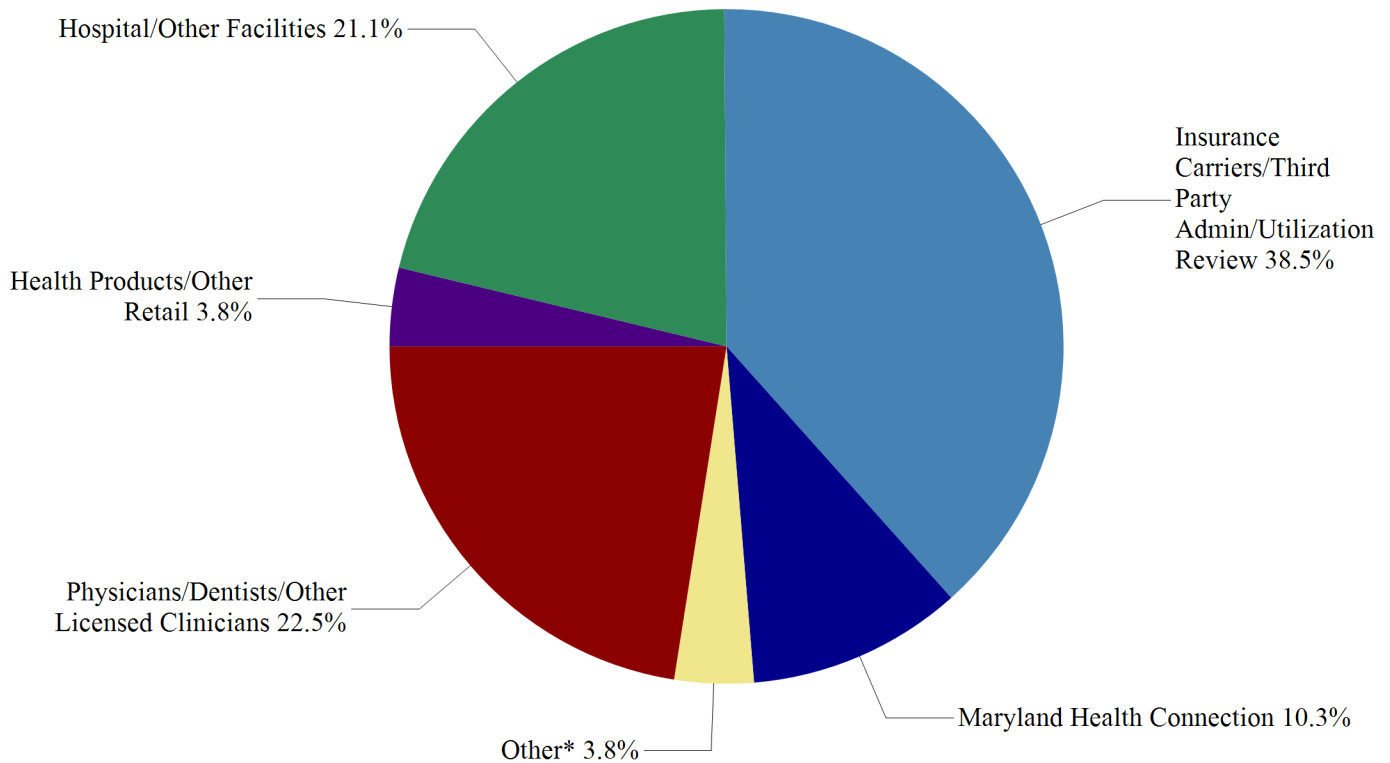
The table below identifies the types of services involved in grievances the MIA investigated during FY 2026. It shows how the outcome varies based on the types of services involved in the grievances. The National Association of Insurance Commissioners defines the types of services identified below.

Type Of Service	Total Grievance Complaints		MIA Upheld Carrier		MIA Overturned Carrier		MIA Modified Carrier		Carrier Reversed Itself During Investigation	
Air Ambulance	4	<1 %	2	50%	1	25%	0	0%	1	25%
Cosmetic	1	<1 %	1	100%	0	0%	0	0%	0	0%
Denial of Hospital Days	5	<1 %	3	60%	1	20%	0	0%	1	20%
Dental Care Services	40	7%	11	28%	2	5%	1	3%	26	65%
Durable Medical Equipment	8	1%	3	38%	2	25%	0	0%	3	38%
Experimental	8	1%	3	38%	2	25%	0	0%	3	38%
Eye Care Services	1	<1 %	0	0%	0	0%	0	0%	1	100%
Genetic Testing	2	<1 %	1	50%	1	50%	0	0%	0	0%
Home Care Services	19	3%	3	16%	13	68%	0	0%	3	16%
In-Patient Rehabilitation Services	9	2%	5	56%	3	33%	0	0%	1	11%
Lab, Imaging, Test Services	126	23%	57	45%	47	37%	0	0%	22	17%
Mental Health/Substance Abuse (Inpatient) Services	12	2%	5	42%	5	42%	1	8%	1	8%
Mental Health/Substance Abuse (Outpatient) Services	7	1%	2	29%	1	14%	0	0%	4	57%
Outpatient Services	2	<1 %	2	100%	0	0%	0	0%	0	0%
Pharmacy Services/Formulary Issues	242	44%	58	24%	61	25%	0	0%	123	51%
Physician Services	56	10%	16	29%	22	39%	2	4%	16	29%
PT, OT, ST Services	4	<1 %	0	0%	2	50%	0	0%	2	50%
Skilled Nursing Facility Care Services	3	<1 %	1	33%	1	33%	0	0%	1	33%
Totals	549	100.0%	173	31.5%	164	29.9%	4	0.7%	208	37.9%

Percentages may not equal 100% due to rounding.

HEAU Cases Subject of Complaints

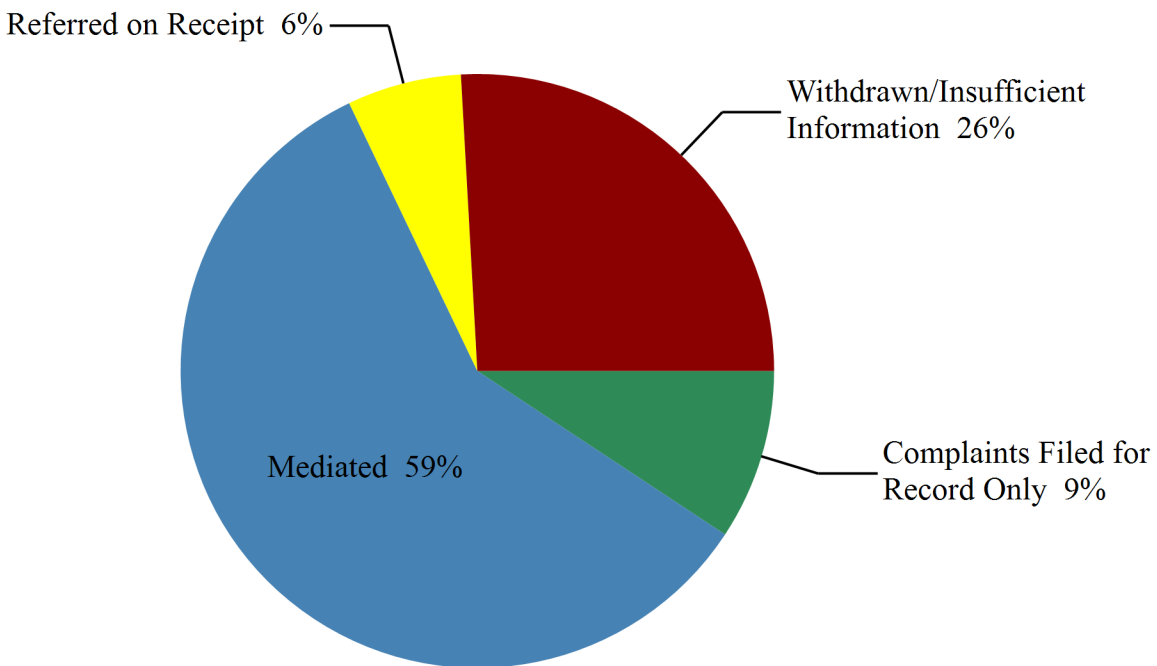
The HEAU mediates a number of different types of patient disputes with health care providers and health insurance carriers. Most complaints involve provider billing or insurance coverage issues, but HEAU cases also involve access to medical records, sales and service problems with health care products, and various other issues encountered in the health care marketplace. In addition, the HEAU assists consumers who experience enrollment difficulties on Maryland Health Connection. The chart below illustrates the types of industries involved in the cases the HEAU closed during FY 2026. The HEAU closed 2,431 complaints. Some complaints were filed against more than one industry.



* "Other" includes Ambulance, Collection/Billing Entities, Broker, Government Agency, Employer, Healthcare Software and other miscellaneous categories.

HEAU Appeals and Grievances Cases Initial Disposition

The HEAU does not mediate all of the Appeals and Grievances complaints filed. Some consumers, or other persons, file complaints but never complete an authorization to release medical records, a form required by the HEAU to mediate the case. Other complaints are filed for the record only or are referred to another more appropriate agency. The chart below details the initial disposition of the 819 Appeals and Grievances cases closed by the HEAU during FY 2026.



HEAU Mediated Appeals and Grievances Cases Carriers, Regulatory Authority and Disposition

The table below identifies the names of the carriers and the outcomes of the Appeals and Grievances cases mediated and closed by the HEAU during FY 2026. “Carriers” are defined in this report to include insurers, nonprofit health service plans, HMOs, dental plans, third-party administrators, utilization review agents, pharmaceutical benefit management companies, and any other entity that provides health benefit plans or adjudicates claims. Some complaints involved more than one carrier; the HEAU mediated and closed 480 cases in FY 2026. Maryland Health Connection is listed as a carrier in cases where the appeal or grievance involved a dispute that required both the carrier and Maryland Health Connection to act to resolve the dispute.

Carrier	Total Cases	Upheld	Overtaken/Modified
Aetna Health Inc.			
State Regulated	25	7	28%
Not State Regulated	21	13	62%
Total Complaints	46	20	43%
Ameritas Life Insurance Corp.			
Not State Regulated	1	1	100%
Total Complaints	1	1	100%
Anthem Blue Cross and Blue Shield			
Not State Regulated	7	5	71%
Total Complaints	7	5	71%
Anthem Blue Cross Blue Shield of Colorado			
Not State Regulated	1	1	100%
Total Complaints	1	1	100%
Blue Cross Blue Shield of Massachusetts			
Not State Regulated	2	2	100%
Total Complaints	2	2	100%
Blue Cross Blue Shield of Michigan			
Not State Regulated	2	0	0%
Total Complaints	2	0	0%
Blue Cross Blue Shield of South Carolina			
Not State Regulated	1	0	0%
Total Complaints	1	0	0%

Carrier	Total Cases	Upheld		Overturned/Modified	
BlueCross BlueShield of Illinois					
Not State Regulated	6	5	83%	1	17%
Total Complaints	6	5	83%	1	17%
CareFirst					
State Regulated	99	32	32%	67	68%
Not State Regulated	65	23	35%	42	65%
Total Complaints	164	55	34%	109	66%
CareFirst Administrators					
Not State Regulated	7	4	57%	3	43%
Total Complaints	7	4	57%	3	43%
CareFirst Dental					
State Regulated	3	0	0%	3	100%
Not State Regulated	2	2	100%	0	0%
Total Complaints	5	2	40%	3	60%
CareFirst FEP Dental					
Not State Regulated	2	2	100%	0	0%
Total Complaints	2	2	100%	0	0%
CIGNA					
State Regulated	6	4	67%	2	33%
Not State Regulated	23	11	48%	12	52%
Total Complaints	29	15	52%	14	48%
Cigna Dental					
Not State Regulated	3	2	67%	1	33%
Total Complaints	3	2	67%	1	33%
CVS Caremark					
State Regulated	8	4	50%	4	50%
Not State Regulated	15	8	53%	7	47%
Total Complaints	23	12	52%	11	48%

Carrier	Total Cases	Upheld		Overturned/Modified	
Davis Vision					
State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Delta Dental					
State Regulated	9	6	67%	3	33%
Total Complaints	9	6	67%	3	33%
Dominion National					
State Regulated	8	4	50%	4	50%
Not State Regulated	2	2	100%	0	0%
Total Complaints	10	6	60%	4	40%
EviCore Healthcare					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Express Scripts					
Not State Regulated	6	5	83%	1	17%
Total Complaints	6	5	83%	1	17%
Freedom Life Insurance Company of America					
State Regulated	3	3	100%	0	0%
Total Complaints	3	3	100%	0	0%
Government Employees Health Association (GEHA)					
Not State Regulated	4	4	100%	0	0%
Total Complaints	4	4	100%	0	0%
Guardian Life Insurance Company of America					
State Regulated	3	1	33%	2	67%
Not State Regulated	6	5	83%	1	17%
Total Complaints	9	6	67%	3	33%
Highmark					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%

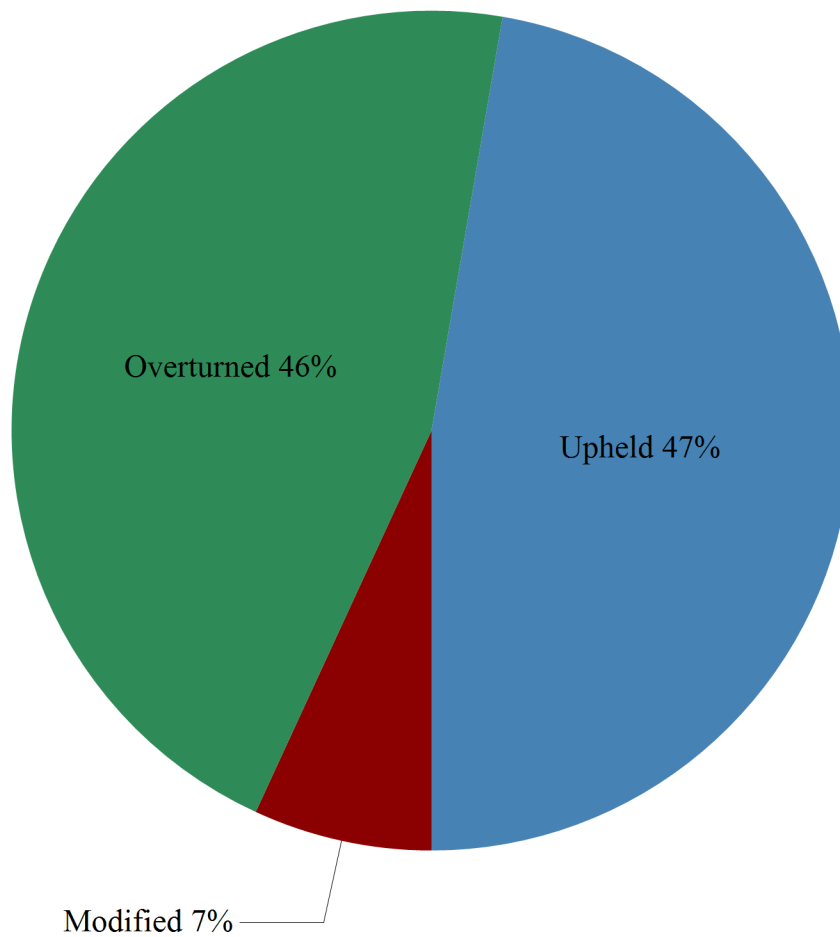
Carrier	Total Cases	Upheld		Overturned/Modified	
Humana Medicare					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Humana Military/Tricare					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Independence Blue Cross Blue Shield					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Johns Hopkins HealthCare LLC					
Not State Regulated	2	0	0%	2	100%
Total Complaints	2	0	0%	2	100%
Johns Hopkins Medicine US Family Health Plan					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Kaiser Permanente of the Mid Atlantic States					
State Regulated	10	2	20%	8	80%
Not State Regulated	10	6	60%	4	40%
Total Complaints	20	8	40%	12	60%
Kroger Prescription Plan					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Luminaire Health					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Maryland Health Connection					
State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%

Carrier	Total Cases	Upheld		Overturned/Modified	
Medicare Complete of United Healthcare					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
MedImpact Healthcare Systems					
Not State Regulated	15	11	73%	4	27%
Total Complaints	15	11	73%	4	27%
MedStar Select					
Not State Regulated	2	1	50%	1	50%
Total Complaints	2	1	50%	1	50%
Meritain Health					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Motion Picture Industry Pension and Health Plans					
Not State Regulated	1	0	0%	1	100%
Total Complaints	1	0	0%	1	100%
Mutual of Omaha					
State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Optum Rx					
State Regulated	2	2	100%	0	0%
Total Complaints	2	2	100%	0	0%
Physicians Mutual Insurance					
State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Principal Life Insurance Company					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
Quantum Health, Inc.					
Not State Regulated	2	0	0%	2	100%
Total Complaints	2	0	0%	2	100%

Carrier	Total Cases	Upheld		Overturned/Modified	
Sentara Health Plans					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
The Prudential Insurance Company of America					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%
United Concordia Insurance Company					
Not State Regulated	2	1	50%	1	50%
Total Complaints	2	1	50%	1	50%
UnitedHealthcare					
State Regulated	60	24	40%	36	60%
Not State Regulated	31	14	45%	17	55%
Total Complaints	91	38	42%	53	58%
Wellcare Value Script					
Not State Regulated	1	1	100%	0	0%
Total Complaints	1	1	100%	0	0%

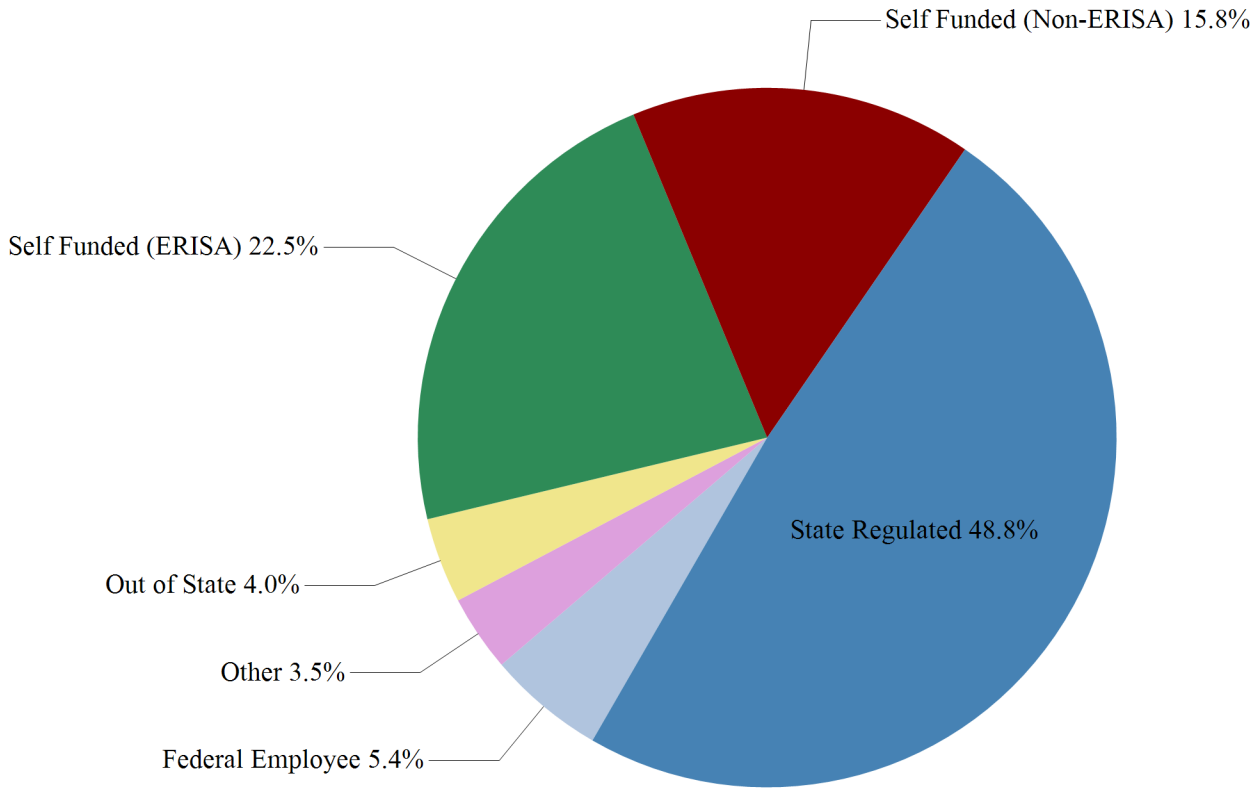
HEAU Mediated Appeals and Grievances Cases Disposition

Carriers may uphold, overturn, or modify their decisions during the appeals and grievances process. The chart below identifies the outcomes of the Appeals and Grievances cases that the HEAU mediated and closed during FY 2026.



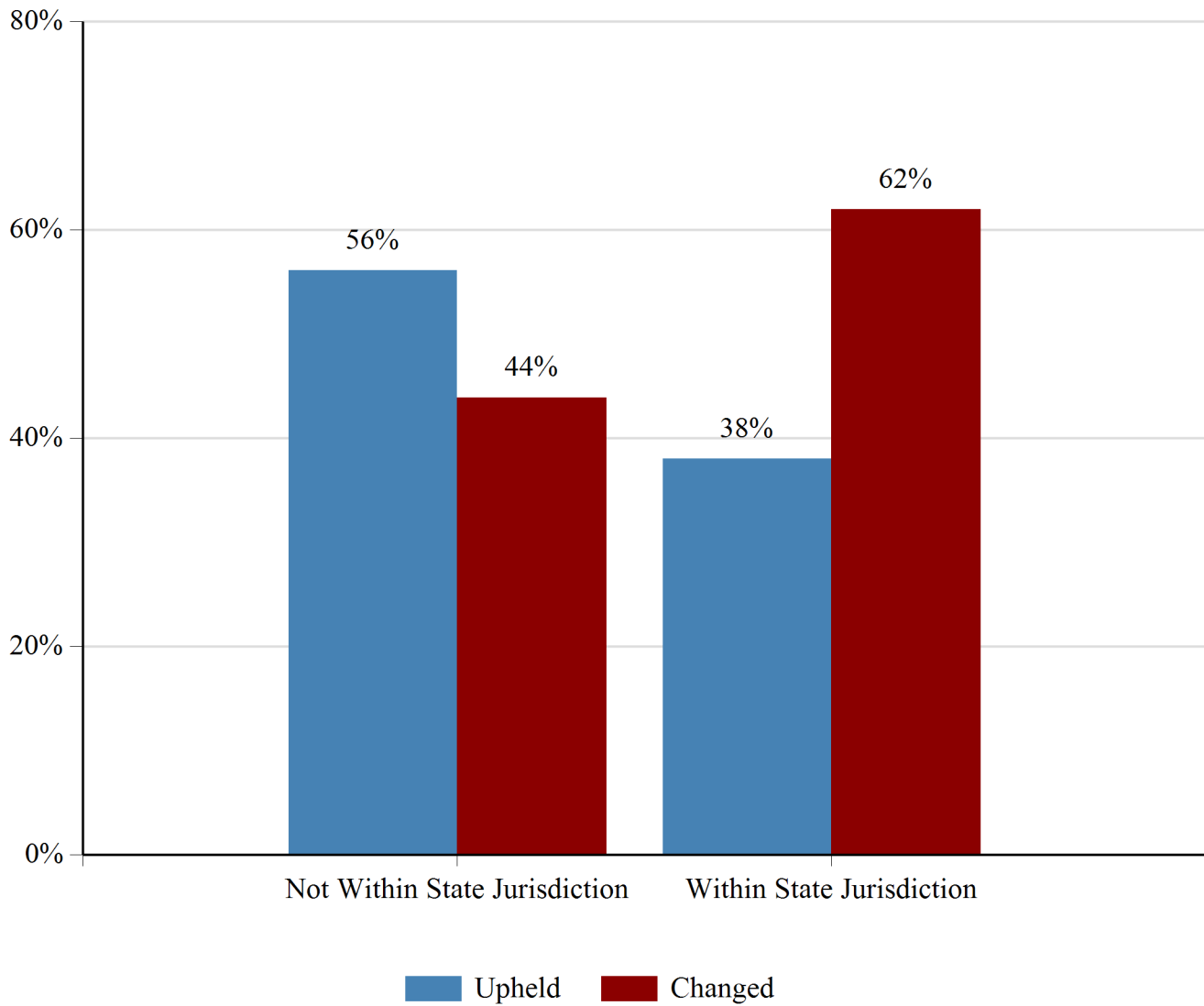
HEAU Mediated Appeals and Grievances Cases Types of Carriers

The chart below identifies the primary carrier types involved in the 480 Appeals and Grievances cases the HEAU mediated and closed during FY 2026.



HEAU Mediated Appeals and Grievances Cases Outcomes Based on MIA Regulatory Authority

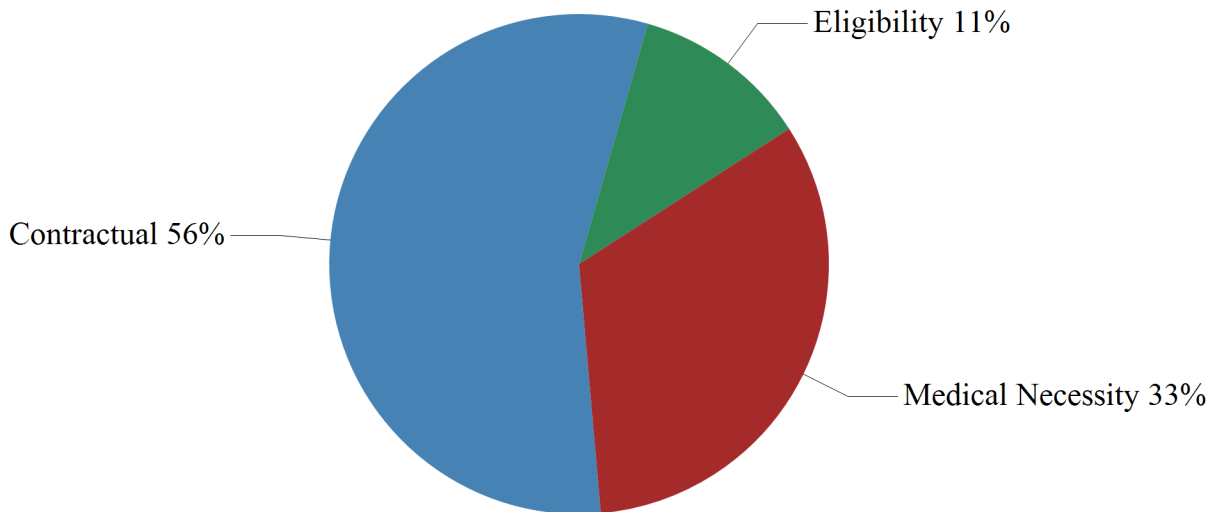
The chart below reflects the outcomes of the 480 Appeals and Grievances cases the HEAU mediated and closed during FY 2026 in relation to the MIA's regulatory authority over the primary carrier. Carriers "Not Within State Jurisdiction" may include: Medicare, Medicaid (Medical Assistance), self-funded plans, federal employee plans, and out-of-state plans.



HEAU Mediated Appeals and Grievances Cases

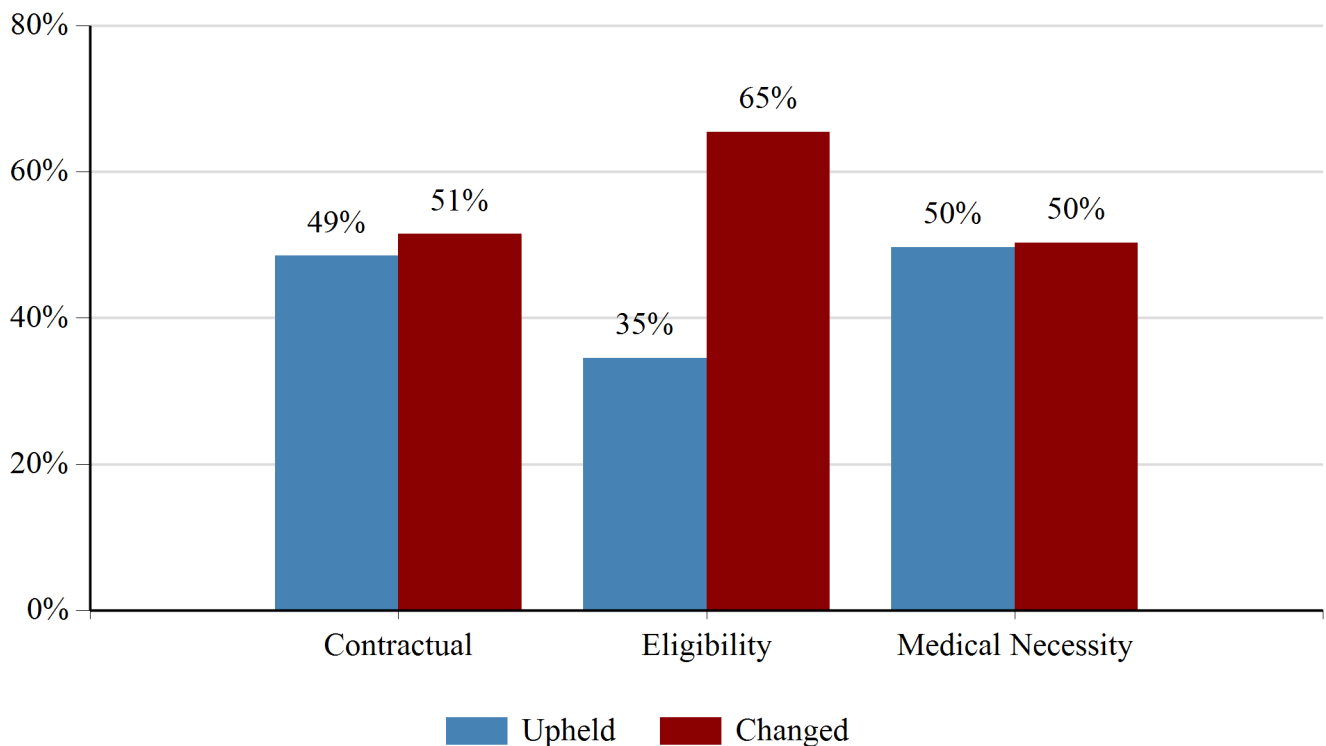
Types of Denials

The HEAU reports data on medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions). The chart below identifies the percentages of each type of case the HEAU mediated and closed during FY 2026.



Outcomes by Denial Type

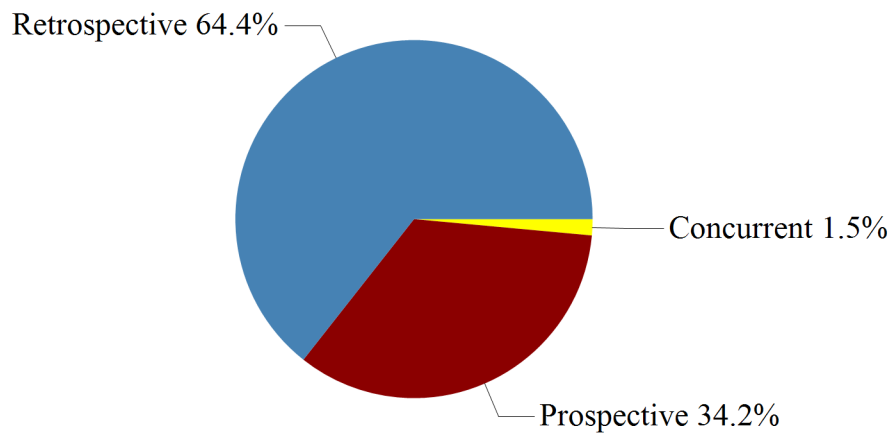
The chart below compares the outcomes of medical necessity, contractual coverage and eligibility disputes (denials, terminations and rescissions) that the HEAU mediated and closed during FY 2026.



HEAU Mediated Appeals and Grievances Cases

Timing of Denials

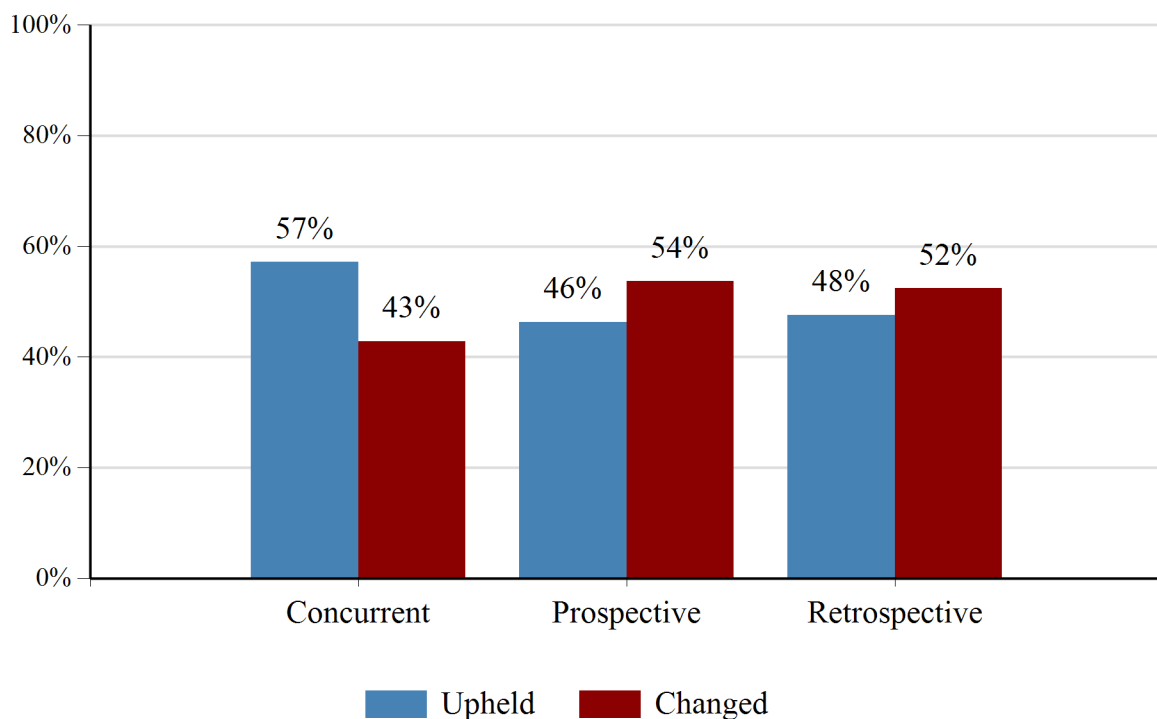
Carriers can deny coverage prior to a provider rendering a service, while a provider is rendering a service, or after a provider renders a service. The chart below identifies the timing of carrier denials for each type of Appeals and Grievances case the HEAU mediated and closed during FY 2026. Eligibility disputes are treated as prospective denials.



Percentages may not equal 100% due to rounding.

Outcomes by Timing of Denials

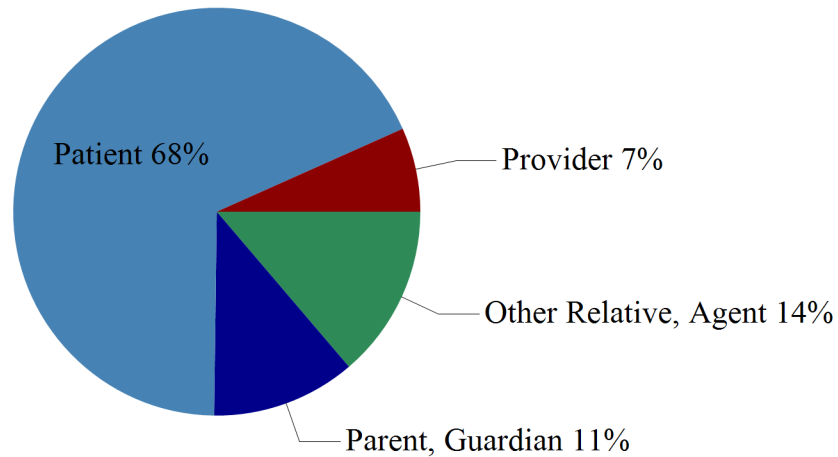
The chart below compares the outcomes of the denials that the HEAU mediated and closed during FY 2026 based on the timing of the decision.



HEAU Mediated Appeals and Grievances Cases

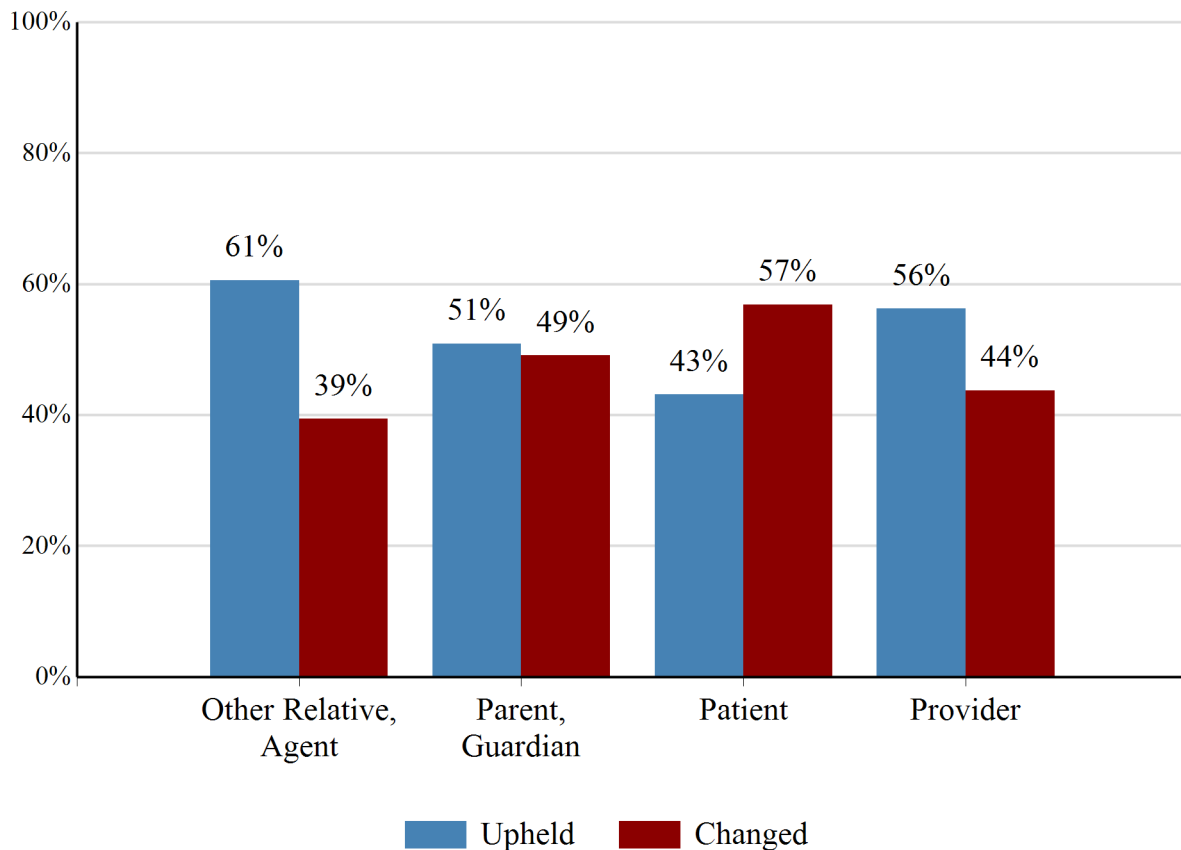
Who Filed the Case

Complaints may be filed by patients or filed on behalf of patients by providers, parents, other relatives, or other agents. The chart below shows who filed Appeals and Grievances cases the HEAU mediated and closed during FY 2026.



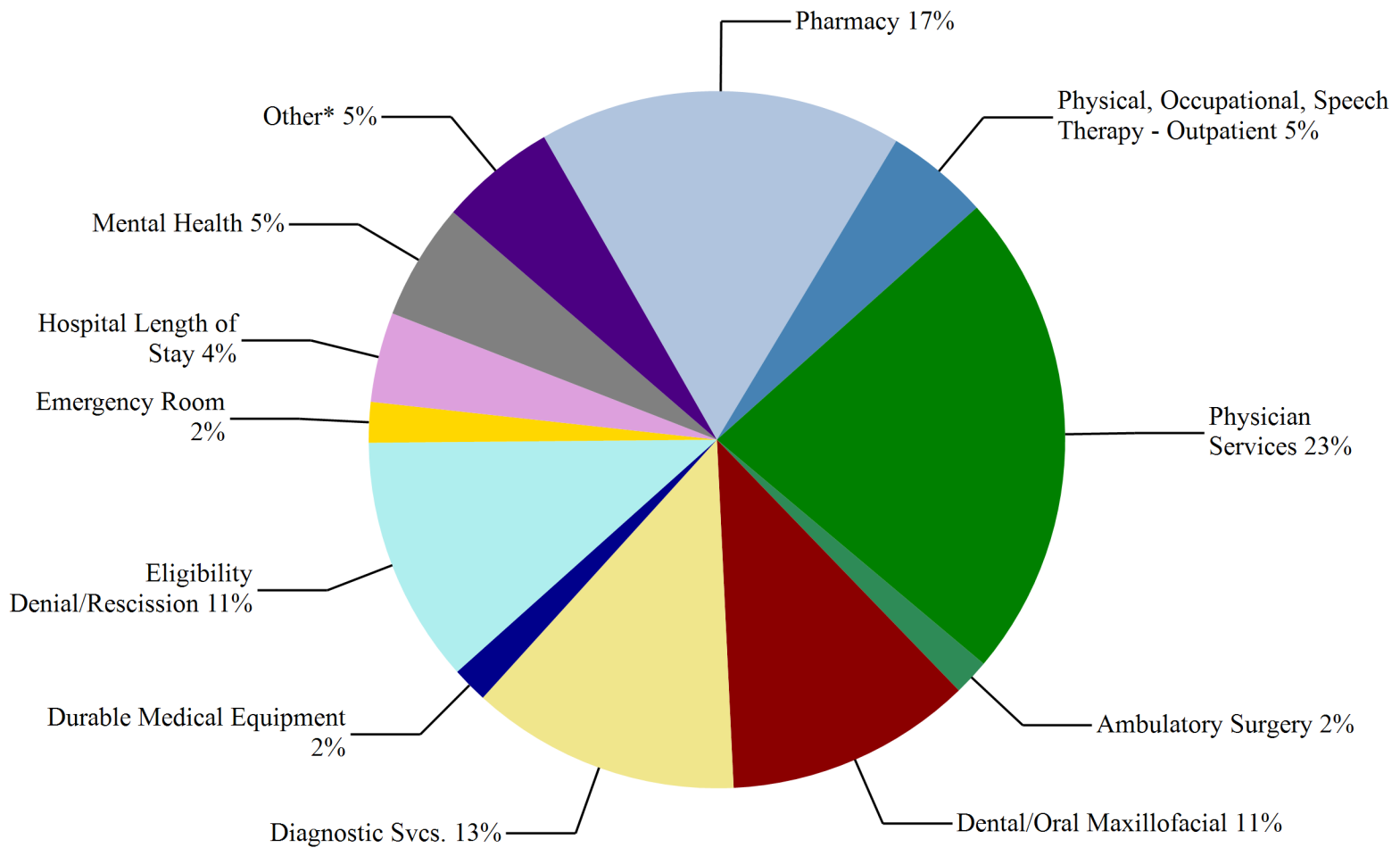
Outcomes by Who Filed the Case

The chart below reflects the outcomes, in relation to who filed the complaint, of the Appeals and Grievances cases the HEAU mediated and closed during FY 2026.



HEAU Mediated Appeals and Grievances Cases Types of Services Denied

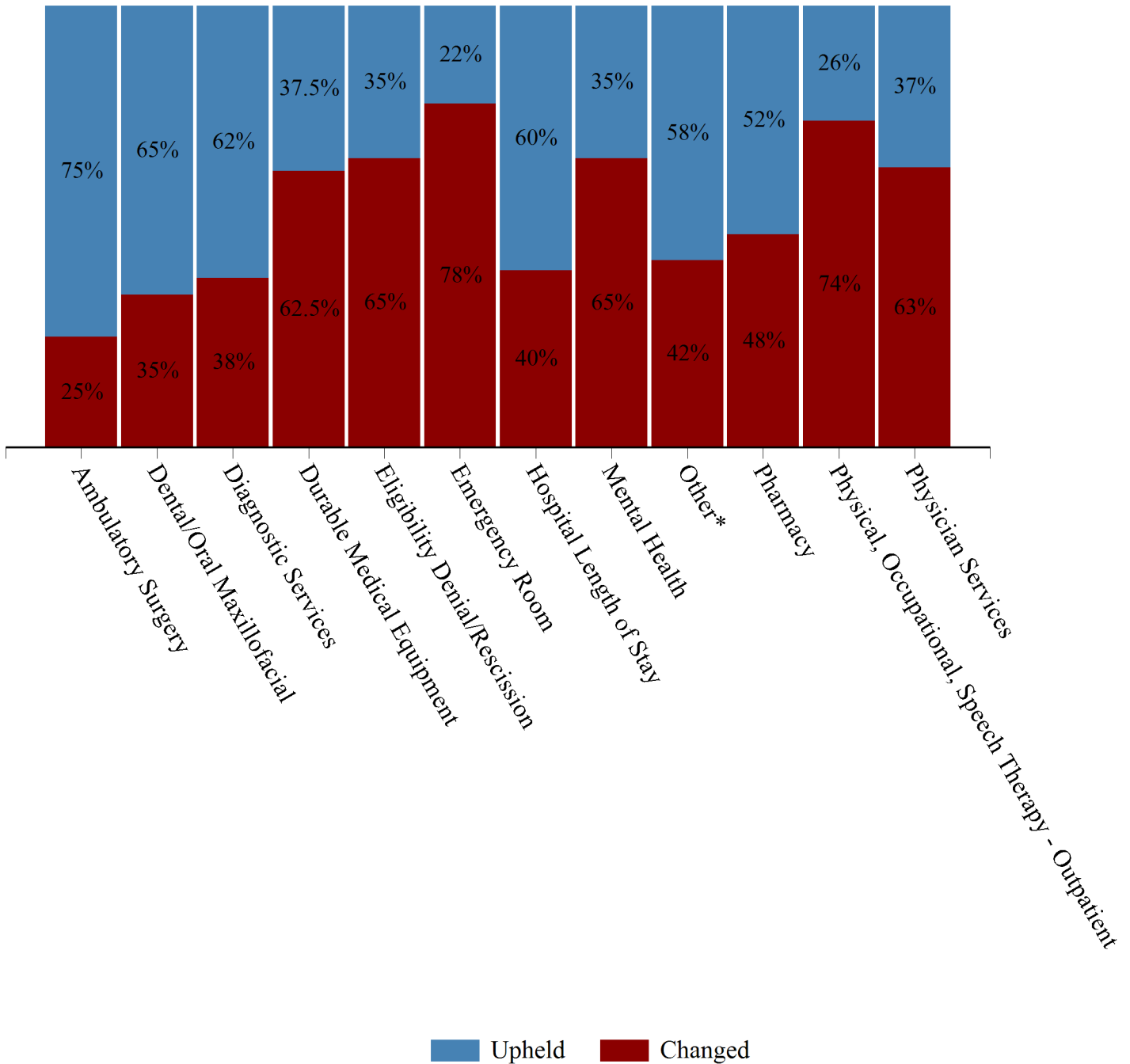
The chart below identifies the types of services involved in the Appeals and Grievances cases the HEAU mediated and closed during FY 2026.



* "Other" includes chiropractic, habilitative services, home health, inpatient rehabilitation, optometry, podiatry, products & supplements, skilled nursing facility and transport.

HEAU Mediated Appeals and Grievances Cases Outcomes by Service Type

The chart below compares the outcomes of the Appeals and Grievances cases the HEAU mediated and closed during FY 2026 based on the types of services denied.



* "Other" includes chiropractic, habilitative services, home health, inpatient rehabilitation, optometry, podiatry, products & supplements, skilled nursing facility and transport.