Maryland
INSURANCE ADMINISTRATION

Workgroup to Study The Rise in Adverse Decisions in the State Health Care System

Meeting # 5 - Questions for Group Discussion

Marie Grant, Insurance Commissioner

Workgroup Charges

From Chapters 671 and 672 of 2025 (Senate Bill 776/HB 995):

f) The Workgroup shall…:

2) make recommendations to improve State reporting on adverse decisions, including recommendations regarding:

i) Standardized definitions of:

1. medical service categories;
2. health settings;
3. adverse decisions; and
4. medical necessity

ii) a standardized method for categorizing adverse decisions and prior authorization denials; and

iii) a standardized process for reporting grievances or filing complaints and appealing adverse decisions;

3) develop strategies for, and make recommendations to reduce, the number of adverse decisions; and

4) develop recommendations for legislation to address the rise in adverse decisions and standardize State reporting requirements regarding adverse decisions across all payers.

Background on Medical Service Categories in the MIA's Appeals and Grievance Report

2024 Report (December 2025)

- Inpatient Hospital Services;
- Emergency Room Services;
- Mental Health Services;
- Physician Services;
- Laboratory, Radiology Services;
- Pharmacy Services;
- PT, OT, ST Services (including inpatient rehab);
- Skilled Nursing Facility Services;
- Durable Medical Equipment Services (DME);
- Dental;
- Home Health Services; and
- Obesity, IVF, Podiatry, and Hearing & Vision.

2025 Report (December 2026)

New categories will include:

- Adverse Decisions regarding Prior Authorization or Step Therapy Protocol;
- Adverse Decisions Overturned after a Reconsideration Request;
- Non-formulary Prescription Drugs - Number of Request made and granted;
- Adverse Decisions Aggregated by Zipcode; and
- Grievance Decisions Aggregated by Zipcode and Adverse Decisions Use of Artificial Intelligence.

2026 Report (December 2027)

Categories will be expanded to include:

- Post-Acute Services - Skilled Nursing Facilities;
- Post-Acute Services - Inpatient Rehabilitation Facilities;
- Post-Acute Services - Inpatient Mental and Behavioral Health Treatment Services; and
- Post-Acute Services - Inpatient Substance Use Treatment Services.

Question 1:

Considering the current and future categories of service that carriers are required to submit to the MIA in the quarterly appeals and grievance reports, are there any gaps in the reported categories of service based on your experiences?

Question 2:

In light of the new regs proposed by the MHCC (Proposed Regulations under COMAR 10.25.06 - Maryland Medical Care Data Base and Data Collection), how should the different types of adverse decisions be categorized? This could include duplicate claims, eligibility issues, out of network claims, and other procedural issues that have nothing to do with prior authorization, medical necessity, or non-compliance with state mandated benefits.

Question 3:

Should there be a standardized form that providers and/or consumers can use to file an appeal to an issuer? Who should create that form? Where should issuers be required to provide that form? In what method should consumers/providers be allowed to submit that form? All of these same questions could be asked about submitted prior authorizations.

Question 4:

The MIA has regulatory authority over - and only receives appeals and grievance data for - commercial and fully-insured health benefit plans in Maryland. Where are there currently gaps within the commercial and fully-insured health plans, and between health plans regulated by other state agencies?

Questions and/or Comments from Public Stakeholders? (as time allows)

Written Comments

Written Comments will be accepted through **EOD Thursday, July 23, 2026** on the topics covered in today's meeting.

Those can be submitted via email to:

riley.williams@maryland.gov and janice.lepore1@maryland.gov.


Thank you