Maryland
INSURANCE ADMINISTRATION

Use of AI for Utilization Review Denials

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This presentation does not provide legal advice. You should discuss specific questions with your trusted financial advisor or insurance producer.

Appeals and Grievances Power BI Dashboard

- The Maryland Insurance Administration is committed to providing transparent, accessible, and meaningful information to consumers, policymakers, and other stakeholders.
- The Appeals and Grievances Power BI Dashboard[1] incorporates several interactive features designed to enhance data exploration and analysis. The hover-over functionality enables users to position their cursor over individual data points to view precise values, including the year and the number of adverse decisions or grievances associated with that point.
- The dashboard also includes list slicers, which display the complete list of companies and services available to view. These slicers allow users to filter the dashboard to isolate and examine data pertaining to a specific company or service of interest.
- Additionally, a multiselect feature permits users to select multiple companies and/or services. Depending on the specific dashboard, this feature will either aggregate the selected values into a cumulative sum or display each selected value independently, allowing direct comparison across companies and services.
- Finally, zoom sliders are provided to support closer examination of the y-axis, particularly for services with smaller values that may otherwise be difficult to distinguish at the default scale.

[1] https://insurance.maryland.gov/Consumer/Pages/ag-bi-dashboard.aspx

Use of AI for Utilization Reviews

- Section 15-10B-07 of the Insurance Article Requires:
  - all adverse decisions shall be made by a licensed physician, or a panel of other appropriate health care service reviewers with at least one physician on the panel, who is:
    i. board certified or eligible in the same specialty as the treatment under review; and
    ii. knowledgeable about the requested health care service or treatment through actual clinical experience.
- Chapter 747 of 2025 (House Bill 820) added to the law multiple requirements related to AI, including:
  - (c)(4) an artificial intelligence, algorithm, or other software tool does not replace the role of a health care provider in the determination process under § 15–10B–07 of this subtitle[.]
  - (d) An artificial intelligence, algorithm, or other software tool may not deny, delay, or modify health care services.
- It has long been the law that an adverse decision may only be made by a physician.

Use of AI Generally

- The NAIC has a model bulletin on the use of AI by insurers. As of April 1, 2026, 25 states, including Maryland, have adopted the model bulletin. Maryland issued it as Bulletin 24-11 on April 22, 2024.
- Insurers should have a governance program, risk management and internal controls, and oversight of third-party AI systems and data. Insurers should be prepared to provide information and documentation to the MIA when asked to do so.
- The NAIC has developed a draft AI systems evaluation tool for states to use when examining an insurer, to guide review of the AI systems. Maryland is part of a pilot project to test and gather feedback on the tool.
- The Financial Regulation division examines risks and governance at insurers, including risks posed by use of AI and the insurer's governance for AI use.

Summary of Meeting #5's Discussion Questions

Question 1: Are there any gaps in the reported categories of service based on your experiences?

- Gap in outpatient service categories (HEAU & MHA).
- Clarify certain services that could fall into multiple categories (MHCC).
    - Example: Glucose monitoring devices could be considered DME or pharmacy services.

Summary of Meeting #5's Discussion Questions

Question 2: How should different types of adverse decisions be categorized?

- MHCC's proposed regulations would collect data on all claims, including denied claims, and the specific codes that are being used. This would still exclude ERISA plans (MHCC).
- Broaden data collection framework to include full spectrum of denials, including administrative and partial denials, alongside those for medical necessity (MHA).
  - Including information regarding where denials are happening.
- Contractual Denials (HEAU).

Summary of Meeting #5's Discussion Questions

Question 3: Should there be a standardized form that providers and/or consumers can use to file an appeal to an issuer? Should there be a standardized form that providers and/or consumers can use to submit prior authorizations?

- Generally a positive reception from health providers (MedChi, MHA, FQHC, MHAMD).
- Standardized forms could provide a few operational challenges from carrier to carrier (League of Life and Health Insurers).
- Carriers recognized this is an area that providers and consumers have experienced challenges (League of Life and Health Insurers).
- Standardized forms are an "an area that varriers would be willing to have an informed and engaged conversation [about]" (League of Life and Health Insurers).
- If forms are developed, there's the potential for claims to be denied because a form is not properly completed (HEAU).
- Explore the state's opportunity to extend comparable prior authorization standards across all payers, including Medicaid MCOs and Medicare Advantage plans, to the extent state and federal law permits (MHA).
- CareFirst voiced concerns about paper forms; Electronically submitted forms are preferred because they have required fields for submission.

Summary of Meeting #5's Discussion Questions

Question 4: Where are there currently gaps within the commercial and fully-insured health plans, and between health plans regulated by other state agencies?

- Interest in collecting initial denials and the internal grievances processes from state and local governmental plans (HEAU).
- MHCC's newly proposed regulations would collect state and local government employee Medical Care Data Base (MCDB) information at the service level (MHCC).

New Question for Discussion

We have heard previously (note: Meeting 5) concerns that individuals may discontinue treatment earlier than clinically recommended due to concerns about coverage or actual denials/adverse decisions - what data is available to reflect that impact?

Questions?

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Thank you