

HOUSE BILL 405

Unofficial Copy  
C3

2000 Regular Session  
(01r0174)

*ENROLLED BILL*  
*-- Economic Matters/Finance --*

Introduced by **Chairman, Economic Matters Committee (Departmental -  
Insurance Administration, Maryland)**

Read and Examined by Proofreaders:

\_\_\_\_\_  
Proofreader.

\_\_\_\_\_  
Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this  
\_\_\_\_ day of \_\_\_\_\_ at \_\_\_\_\_ o'clock, \_\_\_\_ M.

\_\_\_\_\_  
Speaker.

CHAPTER 371

1 AN ACT concerning

2 **Health Insurance - Internal Appeal and Grievance Processes**

3 FOR the purpose of requiring certain carriers to document an adverse decision and to  
4 include certain information in a written notice of an adverse decision to certain  
5 persons; requiring certain carriers to include certain information in a notice of a  
6 grievance decision to certain persons; requiring carriers to establish an internal  
7 appeal process for use by their members and health care providers for disputes  
8 relating to coverage decisions and providing that carriers can comply with this  
9 requirement in a certain manner; requiring carriers to provide certain  
10 information concerning the internal appeal process to members under certain  
11 circumstances; requiring carriers to send members and certain health care  
12 providers written notice of ~~a coverage decision~~ decisions and appeal decisions  
13 within certain time limits under certain circumstances; requiring certain  
14 carriers to include certain information in a notice of ~~a coverage decision~~;  
15 decisions and appeal decisions; authorizing the Insurance Commissioner to  
16 request authorization to release certain records under certain circumstances;

1 requiring carriers to meet the burden of persuasion in certain circumstances;  
 2 authorizing the Commissioner to consider certain information in reviewing a  
 3 complaint; requiring the Commissioner to make and issue a final decision on a  
 4 complaint under certain circumstances; requiring the Commissioner to include  
 5 certain information in a certain notice to certain persons; providing that a  
 6 certain failure of a carrier is a certain violation; authorizing the Commissioner  
 7 to take certain ~~action~~ actions against a carrier for certain violations; authorizing  
 8 the Commissioner to adopt certain regulations; making stylistic and technical  
 9 changes; defining certain terms; providing for a delayed effective date for  
 10 certain provisions of this Act; and generally relating to a carrier's internal  
 11 appeal and grievance processes.

12 BY repealing and reenacting, with amendments,  
 13 Article - Insurance  
 14 Section 15-10A-02(f), (i), (j), and (k)  
 15 Annotated Code of Maryland  
 16 (1997 Volume and 1999 Supplement)

17 BY adding to  
 18 Article - Insurance  
 19 Section 15-10D-01 through ~~15-10D-05~~ 15-10D-04, inclusive, to be under the  
 20 new subtitle "Subtitle 10D. Complaint Process for Coverage Decisions"  
 21 Annotated Code of Maryland  
 22 (1997 Volume and 1999 Supplement)

23 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF  
 24 MARYLAND, That the Laws of Maryland read as follows:

25 **Article - Insurance**

26 15-10A-02.

27 (f) [Except for an emergency case under subsection (b)(2)(i) of this section, at  
 28 the time a member first contacts a carrier about an adverse decision, the carrier shall  
 29 send in writing to the member within 2 working days after the initial contact:

30 (1) the details of its internal grievance process and procedures under the  
 31 provisions of this subtitle;

32 (2) information stating that:

33 (i) the Health Advocacy Unit:

34 1. is available to assist the member with filing a grievance  
 35 under the carrier's internal grievance process; but

36 2. is not available to represent or accompany the member  
 37 during the proceedings of the internal grievance process;

1 (ii) the Health Advocacy Unit can assist the member in mediating a  
 2 resolution of the adverse decision with the carrier, but that any time during the  
 3 mediation, the member or a health care provider on behalf of the member may file a  
 4 grievance; and

5 (iii) the member or a health care provider on behalf of the member  
 6 may file a complaint with the Commissioner without first filing a grievance if  
 7 sufficient information and supporting documentation is filed with the complaint that  
 8 demonstrates a compelling reason to do so;

9 (3) the address, telephone number, facsimile number, and e-mail  
 10 address of the Health Advocacy Unit;

11 (4) the address, telephone number, and facsimile number of the  
 12 Commissioner; and

13 (5) information on where the information required by this subsection can  
 14 be found in the member's policy, plan, certificate, enrollment materials, or other  
 15 evidence of coverage.]

16 FOR NONEMERGENCY CASES, WHEN A CARRIER RENDERS AN ADVERSE  
 17 DECISION, THE CARRIER SHALL:

18 (1) DOCUMENT THE ADVERSE DECISION IN WRITING AFTER THE  
 19 CARRIER HAS PROVIDED ORAL COMMUNICATION OF THE DECISION TO THE MEMBER  
 20 OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER; AND

21 (2) SEND, WITHIN 5 WORKING DAYS AFTER THE ADVERSE DECISION HAS  
 22 BEEN MADE, A WRITTEN NOTICE TO THE MEMBER AND A HEALTH CARE PROVIDER  
 23 ACTING ON BEHALF OF THE MEMBER THAT:

24 (A) (I) STATES IN DETAIL IN CLEAR, UNDERSTANDABLE LANGUAGE  
 25 THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION;

26 (B) (II) REFERENCES THE SPECIFIC CRITERIA AND STANDARDS,  
 27 INCLUDING INTERPRETIVE GUIDELINES, ON WHICH THE DECISION WAS BASED, AND  
 28 MAY NOT SOLELY USE GENERALIZED TERMS SUCH AS "EXPERIMENTAL PROCEDURE  
 29 NOT COVERED", "COSMETIC PROCEDURE NOT COVERED", "SERVICE INCLUDED  
 30 UNDER ANOTHER PROCEDURE", OR "NOT MEDICALLY NECESSARY";

31 (C) (III) STATES THE NAME, BUSINESS ADDRESS, AND BUSINESS  
 32 TELEPHONE NUMBER OF:

33 (A) 1. THE MEDICAL DIRECTOR OR ASSOCIATE MEDICAL DIRECTOR,  
 34 AS APPROPRIATE, WHO MADE THE DECISION IF THE CARRIER IS A HEALTH  
 35 MAINTENANCE ORGANIZATION; OR

36 (B) 2. THE DESIGNATED EMPLOYEE OR REPRESENTATIVE OF  
 37 THE CARRIER WHO HAS RESPONSIBILITY FOR THE CARRIER'S INTERNAL GRIEVANCE  
 38 PROCESS IF THE CARRIER IS NOT A HEALTH MAINTENANCE ORGANIZATION;

1           (4)    (IV)    GIVES WRITTEN DETAILS OF THE CARRIER'S INTERNAL  
2 GRIEVANCE PROCESS AND PROCEDURES UNDER THIS SUBTITLE; AND

3           (5)    (V)    INCLUDES THE FOLLOWING INFORMATION:

4                   (4) 1.    THAT THE MEMBER OR A PROVIDER ON BEHALF OF THE  
5 MEMBER HAS A RIGHT TO FILE A COMPLAINT WITH THE COMMISSIONER WITHIN 30  
6 DAYS AFTER RECEIPT OF A CARRIER'S GRIEVANCE DECISION;

7                   (4) 2.    THAT A COMPLAINT MAY BE FILED WITHOUT FIRST  
8 FILING A GRIEVANCE IF THE MEMBER OR A HEALTH CARE PROVIDER FILING A  
9 GRIEVANCE ON BEHALF OF THE MEMBER CAN DEMONSTRATE A COMPELLING  
10 REASON TO DO SO AS DETERMINED BY THE COMMISSIONER; ~~AND~~

11                   (4) 3.    THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER,  
12 AND FACSIMILE NUMBER; ~~AND~~

13                           4.    A STATEMENT THAT THE HEALTH ADVOCACY UNIT IS  
14 AVAILABLE TO ASSIST THE MEMBER IN BOTH MEDIATING AND FILING A GRIEVANCE  
15 UNDER THE CARRIER'S INTERNAL GRIEVANCE PROCESS; AND

16                           5.    THE ADDRESS, TELEPHONE NUMBER, FACSIMILE  
17 NUMBER, AND EMAIL ADDRESS OF THE HEALTH ADVOCACY UNIT.

18           (6)    ~~INCLUDES THE FOLLOWING DISCLOSURE IN AT LEAST 12 POINT~~  
19 ~~TYPEFACE, WITH THE FIRST SENTENCE IN BOLD CAPITAL TYPEFACE:~~

20    ~~"THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION~~  
21 ~~OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. YOU MAY CONTACT~~  
22 ~~THE HEALTH ADVOCACY UNIT OF MARYLAND'S CONSUMER PROTECTION DIVISION~~  
23 ~~AT (PHONE NUMBER, ADDRESS, FAX, E MAIL).~~

24    ~~THE HEALTH ADVOCACY UNIT CAN HELP YOU AND YOUR HEALTH CARE~~  
25 ~~PROVIDER PREPARE A GRIEVANCE TO FILE UNDER THE CARRIER'S INTERNAL~~  
26 ~~GRIEVANCE PROCEDURE. THAT UNIT CAN ALSO ATTEMPT TO MEDIATE A~~  
27 ~~RESOLUTION TO YOUR DISPUTE. THE HEALTH ADVOCACY UNIT IS NOT AVAILABLE~~  
28 ~~TO REPRESENT OR ACCOMPANY YOU DURING ANY PROCEEDING OF THE INTERNAL~~  
29 ~~GRIEVANCE PROCESS.~~

30    ~~ADDITIONALLY, YOU MAY FILE A COMPLAINT WITH THE MARYLAND~~  
31 ~~INSURANCE ADMINISTRATION, WITHOUT HAVING TO FIRST FILE A GRIEVANCE WITH~~  
32 ~~THE PLAN, IF:~~

33                   (1)    ~~THE PLAN HAS DENIED AUTHORIZATION FOR A HEALTH CARE~~  
34 ~~SERVICE NOT YET PROVIDED TO YOU; AND~~

35                   (2)    ~~YOU OR YOUR PROVIDER CAN SHOW A COMPELLING REASON TO FILE~~  
36 ~~A COMPLAINT, INCLUDING THAT A DELAY IN RECEIVING THE HEALTH CARE SERVICE~~  
37 ~~COULD RESULT IN LOSS OF LIFE, SERIOUS IMPAIRMENT TO A BODILY FUNCTION, OR~~  
38 ~~SERIOUS DYSFUNCTION OF A BODILY ORGAN OR PART, OR THE MEMBER REMAINING~~

~~1 SERIOUSLY MENTALLY ILL WITH SYMPTOMS THAT CAUSE THE MEMBER TO BE A  
2 DANGER TO SELF OR OTHERS. INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO  
3 BE FOUND IN (CITE POLICY, PLAN, CERTIFICATE, ENROLLMENT MATERIALS, OR  
4 OTHER EVIDENCE OF COVERAGE)."~~

5 (i) [(1) For nonemergency cases, each carrier's internal grievance process  
6 established under subsection (a) of this section shall include a provision that requires  
7 the carrier to:

8 (i) document in writing any adverse decision or grievance decision  
9 made by the carrier after the carrier has provided oral communication of the decision  
10 to the member or the health care provider who filed the grievance on behalf of the  
11 member; and

12 (ii) within 5 working days after the decision has been made, send  
13 notice of the adverse decision or grievance decision to:

14 1. the member; and

15 2. if the grievance was filed on behalf of the member under  
16 subsection (b)(2)(iii) of this section, the health care provider.

17 (2) Notice of the adverse decision or grievance decision required to be  
18 sent under paragraph (1) of this subsection shall:]

19 (1) FOR NONEMERGENCY CASES, WHEN A CARRIER RENDERS A  
20 GRIEVANCE DECISION, THE CARRIER SHALL:

21 (I) DOCUMENT THE GRIEVANCE DECISION IN WRITING AFTER THE  
22 CARRIER HAS PROVIDED ORAL COMMUNICATION OF THE DECISION TO THE MEMBER  
23 OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER; AND

24 (II) SEND, WITHIN 5 WORKING DAYS AFTER THE GRIEVANCE  
25 DECISION HAS BEEN MADE, A WRITTEN NOTICE TO THE MEMBER AND A HEALTH  
26 CARE PROVIDER ACTING ON BEHALF OF THE MEMBER THAT:

27 ~~(i)~~ 1. [state] STATES in detail in clear, understandable language the  
28 specific factual bases for the carrier's decision;

29 ~~(ii)~~ 2. [reference] REFERENCES the specific criteria and  
30 standards, including interpretive guidelines, on which the [adverse decision or]  
31 grievance decision was based;

32 ~~(iii)~~ 3. [state] STATES the name, business address, and business  
33 telephone number of:

34 ~~4. A.~~ A. the medical director or associate medical director, as  
35 appropriate, who made the [adverse decision or] grievance decision if the carrier is a  
36 health maintenance organization; or

1 ~~2. B.~~ the designated employee or representative of the carrier  
 2 who has responsibility for the carrier's internal grievance process if the carrier is not  
 3 a health maintenance organization; and

4 ~~(iv)~~ 4. [include] INCLUDES the following information:

5 ~~1. A.~~ that the member has a right to file a complaint with the  
 6 Commissioner within 30 days after receipt of a carrier's grievance decision; AND

7 ~~2.~~ ~~that a complaint may be filed without first filing a~~  
 8 ~~grievance if the member or a health care provider filing a grievance on behalf of the~~  
 9 ~~member can demonstrate a compelling reason to do so; and~~

10 ~~3. B.~~ the Commissioner's address, telephone number, and  
 11 facsimile number.

12 [(3)] (2) A carrier may not use solely in a notice sent under paragraph  
 13 (1) of this subsection generalized terms such as "experimental procedure not covered",  
 14 "cosmetic procedure not covered", "service included under another procedure", or "not  
 15 medically necessary" to satisfy the requirements of [paragraph (2)(i) or (ii) of] this  
 16 subsection.

17 (j) (1) For an emergency case under subsection (b)(2)(i) of this section,  
 18 within 1 day after a decision has been orally communicated to the member or health  
 19 care provider, the carrier shall send notice in writing of any adverse decision or  
 20 grievance decision to:

21 (i) the member; and

22 (ii) if the grievance was filed on behalf of the member under  
 23 subsection (b)(2)(iii) of this section, the health care provider.

24 (2) [The] A notice REQUIRED TO BE SENT UNDER PARAGRAPH (1) OF  
 25 THIS SUBSECTION shall include the [information required under subsection (i)(2) of  
 26 this section] FOLLOWING:

27 (I) FOR AN ADVERSE DECISION, THE INFORMATION REQUIRED  
 28 UNDER SUBSECTION (F) OF THIS SECTION; AND

29 (II) FOR A GRIEVANCE DECISION, THE INFORMATION REQUIRED  
 30 UNDER SUBSECTION (I) OF THIS SECTION.

31 (k) Each carrier shall include the information required by ~~subsections (f) and~~  
 32 ~~[(i)(2)(iii)] (F) SUBSECTION (F)(2)(III), (IV), AND (V)~~ of this section in the policy, plan,  
 33 certificate, enrollment materials, or other evidence of coverage that the carrier  
 34 provides to a member at the time of the member's initial coverage or renewal of  
 35 coverage.

36 SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland  
 37 read as follows:

1 SUBTITLE 10D. COMPLAINT PROCESS FOR COVERAGE DECISIONS.

2 15-10D-01.

3 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS  
4 INDICATED.

5 (B) "APPEAL" MEANS A PROTEST FILED BY A MEMBER OR A HEALTH CARE  
6 PROVIDER WITH A CARRIER UNDER ITS INTERNAL APPEAL PROCESS REGARDING A  
7 COVERAGE DECISION CONCERNING A MEMBER.

8 (C) "APPEAL DECISION" MEANS A FINAL DETERMINATION BY A CARRIER THAT  
9 ARISES FROM AN APPEAL FILED WITH THE CARRIER UNDER ITS APPEAL PROCESS  
10 REGARDING A COVERAGE DECISION CONCERNING A MEMBER.

11 (D) "CARRIER" MEANS A PERSON THAT OFFERS A HEALTH CARE SERVICES  
12 BENEFIT PLAN AND IS:

13 (1) AN AUTHORIZED INSURER THAT PROVIDES HEALTH INSURANCE IN  
14 THE STATE;

15 (2) A NONPROFIT HEALTH SERVICE PLAN;

16 (3) A HEALTH MAINTENANCE ORGANIZATION;

17 (4) A DENTAL PLAN ORGANIZATION; OR

18 (5) EXCEPT FOR A MANAGED CARE ORGANIZATION, AS DEFINED IN  
19 TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE, ANY OTHER PERSON  
20 THAT ~~PROVIDES~~ OFFERS A HEALTH CARE SERVICES BENEFIT PLAN SUBJECT TO  
21 REGULATION BY THE STATE.

22 (E) "COMPLAINT" MEANS A PROTEST FILED WITH THE COMMISSIONER  
23 INVOLVING A COVERAGE DECISION ~~NOT TO PAY A CLAIM FOR HEALTH CARE~~  
24 ~~SERVICES~~ OTHER THAN THAT WHICH IS COVERED BY SUBTITLE 10A OF THIS TITLE.

25 (F) (1) "COVERAGE DECISION" MEANS ~~A FINAL~~ AN INITIAL DETERMINATION  
26 BY A CARRIER OR A REPRESENTATIVE OF THE CARRIER THAT RESULTS IN  
27 NONCOVERAGE OF A HEALTH CARE SERVICE.

28 (2) "COVERAGE DECISION" INCLUDES ~~PAYMENT~~ NONPAYMENT OF ALL  
29 OR ANY PART OF A CLAIM.

30 (3) "COVERAGE DECISION" DOES NOT INCLUDE AN ADVERSE DECISION  
31 AS DEFINED IN § 15-10A-01(B) OF THIS TITLE.

32 (G) (1) "HEALTH BENEFIT PLAN" MEANS:

33 (I) A HOSPITAL OR MEDICAL POLICY OR CONTRACT, INCLUDING A  
34 POLICY OR CONTRACT ISSUED UNDER A MULTIPLE EMPLOYER TRUST OR  
35 ASSOCIATION;

1                   (II)    A HOSPITAL OR MEDICAL POLICY OR CONTRACT ISSUED BY A  
 2 NONPROFIT HEALTH SERVICE PLAN;

3                   (III)   A HEALTH MAINTENANCE ORGANIZATION CONTRACT; OR

4                   (IV)   A DENTAL PLAN ORGANIZATION CONTRACT.

5                   (2)    "HEALTH BENEFIT PLAN" DOES NOT INCLUDE ONE OR MORE, OR ANY  
 6 COMBINATION OF THE FOLLOWING:

7                   (I)     LONG-TERM CARE INSURANCE;

8                   (II)    DISABILITY INSURANCE;

9                   (III)   ACCIDENTAL TRAVEL AND ACCIDENTAL DEATH AND  
 10 DISMEMBERMENT INSURANCE;

11                  (IV)   CREDIT HEALTH INSURANCE; ~~OR~~

12                  (V)     A HEALTH BENEFIT PLAN ISSUED BY A MANAGED CARE  
 13 ORGANIZATION, AS DEFINED IN TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL  
 14 ARTICLE;

15                  (VI)    DISEASE-SPECIFIC INSURANCE; OR

16                  (VII)   FIXED INDEMNITY INSURANCE.

17    ~~(G)~~    (H)    "HEALTH CARE PROVIDER" MEANS:

18                  (1)     AN INDIVIDUAL WHO IS LICENSED UNDER THE HEALTH  
 19 OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES IN THE ORDINARY  
 20 COURSE OF BUSINESS OR PRACTICE OF A PROFESSION AND IS A TREATING PROVIDER  
 21 OF THE MEMBER; OR

22                  (2)     A HOSPITAL, AS DEFINED IN § 19-301 OF THE HEALTH - GENERAL  
 23 ARTICLE.

24    ~~(H)~~ (I)    "HEALTH CARE SERVICE" MEANS A HEALTH OR MEDICAL CARE  
 25 PROCEDURE OR SERVICE RENDERED BY A HEALTH CARE PROVIDER THAT:

26                  (1)     PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF A HUMAN  
 27 DISEASE OR DYSFUNCTION; OR

28                  (2)     DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR  
 29 MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION.

30    ~~(I)~~ (J)    (1)     "MEMBER" MEANS A PERSON ENTITLED TO HEALTH CARE ~~BENEFITS~~  
 31 SERVICES UNDER A POLICY, PLAN, OR ~~CERTIFICATE~~ CONTRACT ISSUED OR  
 32 DELIVERED IN THE STATE BY A CARRIER.

33                  (2)     "MEMBER" INCLUDES:

1 (I) A SUBSCRIBER; AND

2 (II) UNLESS PREEMPTED BY FEDERAL LAW, A MEDICARE  
3 RECIPIENT.

4 (3) "MEMBER" DOES NOT INCLUDE A MEDICAID RECIPIENT.

5 15-10D-02.

6 ~~THIS SUBTITLE APPLIES TO A CARRIER FOR ANY CONTRACT THAT:~~

7 ~~(1) IS DELIVERED OR ISSUED IN THE STATE; OR~~

8 ~~(2) COVERS INDIVIDUALS WHO RESIDE OR WORK IN THE STATE IF THE~~  
9 ~~CONTRACT IS DELIVERED OR ISSUED IN A STATE THAT THE COMMISSIONER~~  
10 ~~DETERMINES DOES NOT HAVE AN EXTERNAL COMPLAINT PROCESS FOR APPEALS~~  
11 ~~COMPARABLE TO THE COMPLAINT PROCESS ESTABLISHED IN THIS SUBTITLE.~~

12 ~~15-10D-03.~~

13 (A) (1) ~~IN ADDITION TO THE REQUIREMENTS OF SUBTITLE 10A OF THIS~~  
14 ~~TITLE,~~ EACH CARRIER SHALL ESTABLISH AN INTERNAL APPEAL PROCESS FOR USE  
15 BY ITS MEMBERS AND HEALTH CARE PROVIDERS TO DISPUTE COVERAGE DECISIONS  
16 MADE BY THE CARRIER.

17 (2) THE CARRIER MAY USE THE INTERNAL GRIEVANCE PROCESS  
18 ESTABLISHED UNDER SUBTITLE 10A OF THIS TITLE TO COMPLY WITH THE  
19 REQUIREMENT OF PARAGRAPH (1) OF THIS SUBSECTION.

20 ~~(B) (1) AN INTERNAL APPEAL PROCESS SHALL INCLUDE AN EXPEDITED~~  
21 ~~PROCEDURE FOR USE IN AN EMERGENCY CASE FOR PURPOSES OF RENDERING AN~~  
22 ~~APPEAL DECISION WITHIN 24 HOURS AFTER THE DATE AN APPEAL IS FILED WITH~~  
23 ~~THE CARRIER.~~

24 ~~(2) THE INTERNAL APPEAL PROCESS SHALL PROVIDE THAT A CARRIER~~  
25 ~~RENDER AN APPEAL DECISION IN WRITING.~~

26 (B) AN INTERNAL APPEAL PROCESS ESTABLISHED BY A CARRIER UNDER THIS  
27 SECTION SHALL PROVIDE THAT A CARRIER RENDER A FINAL DECISION IN WRITING  
28 TO A MEMBER, AND A HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER,  
29 WITHIN 60 WORKING DAYS AFTER THE DATE ON WHICH THE APPEAL IS FILED.

30 (C) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, THE  
31 CARRIER'S INTERNAL APPEAL PROCESS SHALL BE EXHAUSTED PRIOR TO FILING A  
32 COMPLAINT WITH THE COMMISSIONER UNDER THIS SUBTITLE.

33 (D) ~~(1)~~ A MEMBER OR A HEALTH CARE PROVIDER FILING A COMPLAINT ON  
34 BEHALF OF A MEMBER MAY FILE A COMPLAINT WITH THE COMMISSIONER WITHOUT  
35 FIRST FILING AN APPEAL WITH A CARRIER ONLY IF THE COVERAGE DECISION  
36 INVOLVES AN URGENT MEDICAL CONDITION, AS DEFINED BY REGULATION ADOPTED

1 BY THE COMMISSIONER, FOR WHICH CARE HAS NOT BEEN RENDERED AND  
2 RECEIVING AN APPEAL DECISION IF THE MEMBER OR THE HEALTH CARE PROVIDER  
3 PROVIDES SUFFICIENT INFORMATION AND SUPPORTING DOCUMENTATION IN THE  
4 COMPLAINT THAT DEMONSTRATES A COMPELLING REASON TO DO SO.

5 (2) ~~THE COMMISSIONER SHALL DEFINE BY REGULATION THE~~  
6 ~~STANDARDS THAT THE COMMISSIONER SHALL USE TO DECIDE WHAT~~  
7 ~~DEMONSTRATES A COMPELLING REASON UNDER PARAGRAPH (1) OF THIS~~  
8 ~~SUBSECTION.~~

9 (E) (1) ~~FOR NONEMERGENCY CASES, EACH CARRIER'S INTERNAL APPEAL~~  
10 ~~PROCESS ESTABLISHED UNDER SUBSECTION (A) OF THIS SECTION SHALL INCLUDE A~~  
11 ~~PROVISION THAT REQUIRES THE CARRIER TO:~~

12 (I) ~~DOCUMENT IN WRITING ANY COVERAGE DECISION OR APPEAL~~  
13 ~~DECISION MADE BY THE CARRIER; AND~~

14 (II) ~~WITHIN 5 WORKING DAYS AFTER THE DECISION HAS BEEN~~  
15 ~~MADE, SEND NOTICE OF THE COVERAGE DECISION OR APPEAL DECISION TO:~~

16 1. ~~THE MEMBER; AND~~

17 2. ~~IF THE GRIEVANCE WAS FILED ON BEHALF OF THE~~  
18 ~~MEMBER, THE HEALTH CARE PROVIDER.~~

19 (2) ~~NOTICE OF THE COVERAGE DECISION OR APPEAL DECISION~~  
20 ~~REQUIRED TO BE SENT UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:~~

21 (I) ~~STATE IN DETAIL IN CLEAR, UNDERSTANDABLE LANGUAGE~~  
22 ~~THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION;~~

23 (II) ~~INCLUDE THE FOLLOWING INFORMATION:~~

24 1. ~~THAT THE MEMBER HAS A RIGHT TO FILE A COMPLAINT~~  
25 ~~WITH THE COMMISSIONER WITHIN 30 DAYS AFTER RECEIPT OF A CARRIER'S APPEAL~~  
26 ~~DECISION;~~

27 2. ~~THAT A COMPLAINT MAY BE FILED WITHOUT FIRST~~  
28 ~~FILING AN APPEAL IF THE MEMBER OR A HEALTH CARE PROVIDER FILING AN~~  
29 ~~APPEAL ON BEHALF OF THE MEMBER CAN DEMONSTRATE A COMPELLING REASON~~  
30 ~~TO DO SO; AND~~

31 3. ~~THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER,~~  
32 ~~AND FACSIMILE NUMBER.~~

33 (E) (1) WITHIN 30 CALENDAR DAYS AFTER A COVERAGE DECISION HAS  
34 BEEN MADE, A CARRIER SHALL SEND A WRITTEN NOTICE OF THE COVERAGE  
35 DECISION TO THE MEMBER AND, IN THE CASE OF A HEALTH MAINTENANCE  
36 ORGANIZATION, THE TREATING HEALTH CARE PROVIDER.

1           (2)     NOTICE OF THE COVERAGE DECISION REQUIRED TO BE SENT UNDER  
2 PARAGRAPH (1) OF THIS SUBSECTION SHALL:

3           (I)     STATE IN DETAIL IN CLEAR, UNDERSTANDABLE LANGUAGE,  
4 THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION; AND

5           (II)    INCLUDE THE FOLLOWING INFORMATION:

6                   1.     THAT THE MEMBER, OR A HEALTH CARE PROVIDER  
7 ACTING ON BEHALF OF THE MEMBER, HAS A RIGHT TO FILE AN APPEAL WITH THE  
8 CARRIER;

9                   2.     THAT THE MEMBER, OR A HEALTH CARE PROVIDER  
10 ACTING ON BEHALF OF THE MEMBER, MAY FILE A COMPLAINT WITH THE  
11 COMMISSIONER WITHOUT FIRST FILING AN APPEAL, IF THE COVERAGE DECISION  
12 INVOLVES AN URGENT MEDICAL CONDITION FOR WHICH CARE HAS NOT BEEN  
13 RENDERED; AND

14                  3.     THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER,  
15 AND FACSIMILE NUMBER;

16                  4.     THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO  
17 ASSIST THE MEMBER IN BOTH MEDIATING AND FILING AN APPEAL UNDER THE  
18 CARRIER'S INTERNAL APPEAL PROCESS; AND

19                  5.     THE ADDRESS, TELEPHONE NUMBER, FACSIMILE  
20 NUMBER, AND EMAIL ADDRESS OF THE HEALTH ADVOCACY UNIT.

21     (F)     (1)     WITHIN 30 CALENDAR DAYS AFTER THE APPEAL DECISION HAS BEEN  
22 MADE, EACH CARRIER SHALL SEND TO THE MEMBER, AND THE HEALTH CARE  
23 PROVIDER ACTING ON BEHALF OF THE MEMBER, A WRITTEN NOTICE OF THE APPEAL  
24 DECISION.

25           (2)     NOTICE OF THE APPEAL DECISION REQUIRED TO BE SENT UNDER  
26 PARAGRAPH (1) OF THE SUBSECTION SHALL:

27           (I)     STATE IN DETAIL IN CLEAR, UNDERSTANDABLE LANGUAGE  
28 THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION; AND

29           (II)    INCLUDE THE FOLLOWING INFORMATION:

30                   1.     THAT THE MEMBER, OR A HEALTH CARE PROVIDER  
31 ACTING ON BEHALF OF THE MEMBER, HAS A RIGHT TO FILE A COMPLAINT WITH THE  
32 COMMISSIONER WITHIN 60 WORKING DAYS AFTER RECEIPT OF A CARRIER'S APPEAL  
33 DECISION; AND

34                  2.     THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER,  
35 AND FACSIMILE NUMBER.

1     ~~(F)~~     (G)     THE COMMISSIONER MAY REQUEST THE MEMBER THAT FILED THE  
2 COMPLAINT OR A LEGALLY AUTHORIZED DESIGNEE OF THE MEMBER TO SIGN A  
3 CONSENT FORM AUTHORIZING THE RELEASE OF THE MEMBER'S MEDICAL RECORDS  
4 TO THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE THAT ARE NEEDED IN  
5 ORDER FOR THE COMMISSIONER TO MAKE A FINAL DECISION ON THE COMPLAINT.

6     ~~(G)~~     (H)     (1)     DURING THE REVIEW OF A COMPLAINT BY THE COMMISSIONER  
7 OR A DESIGNEE OF THE COMMISSIONER, A CARRIER SHALL HAVE THE BURDEN OF  
8 PERSUASION THAT ITS COVERAGE DECISION OR APPEAL DECISION, AS APPLICABLE,  
9 IS CORRECT.

10           (2)     AS PART OF THE REVIEW OF A COMPLAINT, THE COMMISSIONER OR  
11 A DESIGNEE OF THE COMMISSIONER MAY CONSIDER ALL OF THE FACTS OF THE  
12 CASE AND ANY OTHER EVIDENCE THAT THE COMMISSIONER OR DESIGNEE OF THE  
13 COMMISSIONER CONSIDERS APPROPRIATE.

14     ~~(H)~~     (I)     THE COMMISSIONER SHALL:

15           (1)     MAKE AND ISSUE IN WRITING A FINAL DECISION ON ALL  
16 COMPLAINTS FILED WITH THE COMMISSIONER UNDER THIS SUBTITLE THAT ARE  
17 WITHIN THE COMMISSIONER'S JURISDICTION; AND

18           (2)     PROVIDE NOTICE IN WRITING TO ALL PARTIES TO A COMPLAINT OF  
19 THE OPPORTUNITY AND TIME PERIOD FOR REQUESTING A HEARING TO BE HELD IN  
20 ACCORDANCE WITH TITLE 10 SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE TO  
21 CONTEST A FINAL DECISION OF THE COMMISSIONER MADE AND ISSUED UNDER THIS  
22 SUBTITLE.

23 ~~15-10D-04.~~ 15-10D-03.

24     (A)     IT IS A VIOLATION OF THIS SUBTITLE FOR A CARRIER TO FAIL TO FULFILL  
25 THE CARRIER'S OBLIGATIONS TO PROVIDE OR REIMBURSE FOR HEALTH CARE  
26 SERVICES SPECIFIED IN THE CARRIER'S POLICIES OR CONTRACTS WITH MEMBERS.

27     (B)     IF, IN RENDERING A COVERAGE DECISION OR APPEAL DECISION, A  
28 CARRIER FAILS TO FULFILL THE CARRIER'S POLICIES OR CONTRACTS WITH  
29 MEMBERS, THE COMMISSIONER MAY:

30           (1)     ISSUE AN ADMINISTRATIVE ORDER THAT REQUIRES THE CARRIER  
31 TO:

32                   (I)     CEASE INAPPROPRIATE CONDUCT OR PRACTICES BY THE  
33 CARRIER OR ANY OF THE PERSONNEL EMPLOYED OR ASSOCIATED WITH THE  
34 CARRIER;

35                   (II)    FULFILL THE CARRIER'S CONTRACTUAL OBLIGATIONS;

36                   (III)   PROVIDE A HEALTH CARE SERVICE OR PAYMENT THAT HAS  
37 BEEN DENIED IMPROPERLY; OR

1 (IV) TAKE APPROPRIATE STEPS TO RESTORE THE CARRIER'S  
2 ABILITY TO PROVIDE A HEALTH CARE SERVICE OR PAYMENT THAT IS PROVIDED  
3 UNDER A CONTRACT; OR

4 (2) IMPOSE ANY PENALTY OR FINE OR TAKE ANY ACTION AS  
5 AUTHORIZED:

6 (I) FOR AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR  
7 DENTAL PLAN ORGANIZATION, UNDER THIS ARTICLE; OR

8 (II) FOR A HEALTH MAINTENANCE ORGANIZATION, UNDER THE  
9 HEALTH - GENERAL ARTICLE OR UNDER THIS ARTICLE.

10 ~~15-10D-05.~~ 15-10D-04.

11 THE COMMISSIONER MAY ADOPT ANY NECESSARY REGULATIONS TO CARRY  
12 OUT THE PROVISIONS OF THIS SUBTITLE.

13 SECTION 3. AND BE IT FURTHER ENACTED, That, notwithstanding any  
14 policy or benefit statement to the contrary, Section 2 of this Act shall take effect  
15 January 1, 2001.

16 SECTION 4. AND BE IT FURTHER ENACTED, That, except as provided in  
17 Section 3 of this Act, this Act shall take effect ~~July 1, 2000~~ October 1, 2000.