Chapter 72

(Senate Bill 790)

AN ACT concerning

Health Insurance – Communications Between Carriers and Enrollees – Conformity With the Health Insurance Portability and Accountability Act (HIPAA)

FOR the purpose of requiring the Maryland Insurance Commissioner to develop and make available a certain form for enrollees to use to request confidential communications from certain health insurance carriers in accordance with certain provisions of federal law; requiring carriers to accept a certain form for a certain purpose under certain circumstances; providing that a certain notice given by an insurer under certain circumstances is subject to certain provisions of federal law; providing that a certain explanation of benefits is subject to certain provisions of federal law; defining certain terms; providing for the construction of certain provisions of this Act; making this Act an emergency measure; and generally relating to conformity of insurance communications with provisions of the federal Health Insurance Portability and Accountability Act.

BY adding to
Article – Health – General
Section 19–706(oooo)
Annotated Code of Maryland
(2009 Replacement Volume and 2013 Supplement)

BY adding to
Article – Insurance
Section 15–141
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1006 and 15–1007
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

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

Article – Health – General

19–706.

(OOOO) THE PROVISIONS OF § 15–141 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article – Insurance

15–141.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A DENTAL PLAN ORGANIZATION; OR

(V) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

(3) "ENROLLEE" MEANS A PERSON ENTITLED TO HEALTH CARE BENEFITS FROM A CARRIER.

(B) THE COMMISSIONER SHALL DEVELOP AND MAKE AVAILABLE A STANDARDIZED FORM FOR AN ENROLLEE TO USE TO REQUEST CONFIDENTIAL COMMUNICATIONS FROM A CARRIER IN ACCORDANCE WITH 45 C.F.R. § 164.522(B).

(C) A CARRIER THAT REQUIRES AN ENROLLEE TO MAKE A REQUEST FOR CONFIDENTIAL COMMUNICATIONS IN WRITING IN ACCORDANCE WITH 45 C.F.R. § 164.522(B) SHALL ACCEPT THE STANDARDIZED FORM DEVELOPED BY THE COMMISSIONER UNDER THIS SECTION FOR THAT PURPOSE.

(D) THIS SECTION MAY NOT BE CONSTRUED TO LIMIT ACCEPTANCE BY A CARRIER OF ANY OTHER FORM OF WRITTEN REQUEST FROM AN ENROLLEE FOR CONFIDENTIAL COMMUNICATIONS FROM A CARRIER UNDER 45 C.F.R. § 164.522(B).

15–1006.

(a) On written request of the claimant, an insurer that denies a claim made on an individual health insurance policy shall give written notice to the claimant that states fully the reason for the denial.

(b) The reason given by an insurer for denial of a claim shall not act as an estoppel or limit the insurer from offering an additional reason for the denial.

(C) THE NOTICE GIVEN BY AN INSURER UNDER THIS SECTION IS SUBJECT TO 45 C.F.R. § 164.522(B).

15–1007.

(a) This section applies to insurers and nonprofit health service plans that propose to issue or deliver individual, group, or blanket health insurance policies or contracts or to administer health benefit programs that provide hospital, medical, or surgical benefits on an expense–incurred basis.

(b) Each entity subject to this section shall provide to an insured individual who has filed a claim described in subsection (c) of this section an annual summary explanation of benefits that covers the preceding 12–month period.

(c) The summary explanation of benefits required under subsection (b) of this section shall provide a summary of:

(1) all claims filed by health care providers for services rendered to the insured individual or covered dependent of the insured individual during an inpatient hospitalization or an outpatient surgical procedure;

(2) the amount paid by the entity for each claim filed; and

(3) the balance owed by the insured individual for each claim filed.

(D) THE EXPLANATION OF BENEFITS REQUIRED UNDER THIS SECTION IS SUBJECT TO 45 C.F.R. § 164.522(B).

SECTION 2. AND BE IT FURTHER ENACTED, That this Act ~~shall take effect October 1, 2014~~ is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

Approved by the Governor, April 8, 2014.