BY: Finance Committee

AMENDMENTS TO HOUSE BILL NO. 823
(Third Reading File Bill)

AMENDMENT NO. 1

On page 1, strike beginning with the second "Health" in line 2 down through "Complaints" in line 3 and substitute "Complaint Process for Adverse Decisions or Grievances"; in lines 4 and 5, and in line 6, in each instance, strike "complaint and review" and substitute "grievance"; strike beginning with "requiring" in line 8 down through "process;" in line 10; strike beginning with "written" in line 11 down through "notice" in line 12 and substitute "certain information when the member contacts the carrier concerning an adverse decision"; in line 14, after "time;" insert "requiring the Health Education and Advocacy Unit to refer to the Commissioner a certain member, to transmit certain information to the Commissioner, and to establish a certain toll-free telephone number;"; in line 20, strike "and appeals"; in line 21, after "circumstances;" insert "requiring the Commissioner to advise certain parties of the opportunity for requesting a certain hearing;"; strike beginning with the first "and" in line 22 down through "or" in line 23 and substitute "to"; and in line 24, strike "a certain report" and substitute "certain reports".

On page 2, in line 1, strike the first "the" and substitute "a certain"; strike beginning with "making" in line 3 down through "practice" in line 4 and substitute "requiring carriers to submit a certain report to the Commissioner; providing that the improper failure of an insurer or nonprofit health service plan to reimburse for medically necessary covered benefits is an unfair claim settlement practice"; in line 8, after "date;" insert "requiring a certain Maryland Insurance Administration annual report to provide certain information;"; in line 9, after the second "Act;" insert "providing for the termination of certain provisions of this Act;"; and in line 10, strike "and appeals".

AMENDMENT NO. 2

On page 2, after line 23, insert:

"BY adding to
Article - Insurance

Section 2-104(k)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter 36 of the General Assembly of 1995, as amended by Chapter 352 of the Acts of the General Assembly of 1995, as amended by Chapter 271 of the Acts of the General Assembly of 1996)";

in line 26, strike "15-1406" and substitute "15-1405"; in line 34, strike "27-303" and substitute "27-304"; and strike beginning with "Adverse" in line 27 down through "Plans" in line 28 and substitute "Complaint Process for Adverse Decisions or Grievances".

On pages 2 and 3, strike the lines beginning with line 38 on page 2 through line 2 on page 3, inclusive.

AMENDMENT NO. 3

On page 3, after line 16 insert:

"Preamble

WHEREAS, There has been an active commitment by the Maryland General Assembly to provide the public with protections and access to the most cost effective and efficient health care system in the country; and

WHEREAS, Laws providing some of these protections can be found in various sections of Maryland law, involving the Maryland Insurance Administration, the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General, and the Department of Health and Mental Hygiene; and

WHEREAS, There is no clear and expeditious manner for the public to seek clarification and resolution of their concerns with respect to coverage of health benefits; and

WHEREAS, Consumers would benefit from a single point of entry for the resolution of complaints and appeals through a unified procedure which all parties may utilize; now, therefore,".

AMENDMENT NO. 4

On pages 3 through 12, strike the lines beginning with line 30 on page 3 through line 38 on

page 12, inclusive, and substitute:

"2-104.

(K) THE COMMISSIONER MAY UTILIZE PHYSICIANS OR PERSONS THAT ARE LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO PRACTICE A HEALTH OCCUPATION IN THIS STATE OR ANY OTHER STATE, TO ADVISE THE COMMISSIONER ON MEDICAL ISSUES RELATED TO ADVERSE DECISIONS OR GRIEVANCE DECISIONS.

SUBTITLE 14. COMPLAINT PROCESS FOR ADVERSE DECISIONS OR GRIEVANCES.

15-1401.

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

(B) "ADVERSE DECISION" MEANS A UTILIZATION REVIEW DETERMINATION MADE BY A PRIVATE REVIEW AGENT, A CARRIER, OR A LICENSED OR CERTIFIED PROVIDER ACTING ON BEHALF OF THE CARRIER THAT A PROPOSED OR DELIVERED HEALTH CARE SERVICE:

(1) IS OR WAS NOT NECESSARY, APPROPRIATE, OR EFFICIENT; AND

(2) MAY RESULT IN NONCOVERAGE OF THE HEALTH CARE SERVICE.

(C) "ADVISORY COMMITTEE" MEANS A COMMITTEE OF IMPARTIAL HEALTH CARE PROFESSIONALS USED BY THE COMMISSIONER TO ADVISE THE COMMISSIONER WITH RESPECT TO COMPLAINTS FILED UNDER THIS SUBTITLE.

(D) "CARRIER" MEANS:

(1) AN INSURER;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION;

(4) A DENTAL PLAN ORGANIZATION; OR

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

(E) "COMPLAINT" MEANS A PROTEST FILED WITH THE COMMISSIONER BY A MEMBER CONCERNING AN ADVERSE DECISION OR GRIEVANCE DECISION BY A CARRIER CONCERNING THE MEMBER.

(F) "GRIEVANCE" MEANS A PROTEST FILED WITH A CARRIER, THROUGH ITS INTERNAL GRIEVANCE PROCESS, BY A MEMBER REGARDING A CARRIER'S ADVERSE DECISION CONCERNING THE MEMBER.

(G) "HEALTH ADVOCACY UNIT" MEANS THE HEALTH EDUCATION AND ADVOCACY UNIT IN THE DIVISION OF CONSUMER PROTECTION OF THE OFFICE OF THE ATTORNEY GENERAL.

(H) (1) "MEMBER" MEANS A PERSON ENTITLED TO BENEFITS UNDER A POLICY OR PLAN ISSUED OR DELIVERED IN THE STATE BY A CARRIER.

(2) "MEMBER" INCLUDES A SUBSCRIBER.

15-1402.

(A) EACH CARRIER SHALL ESTABLISH AN INTERNAL GRIEVANCE PROCESS FOR MEMBERS.

(B) (1) THE INTERNAL GRIEVANCE PROCESS SHALL MEET THE SAME REQUIREMENTS ESTABLISHED UNDER TITLE 19, SUBTITLE 13 OF THE HEALTH - GENERAL ARTICLE.

(2) IN ADDITION TO THE REQUIREMENTS OF TITLE 19, SUBTITLE 13 OF THE HEALTH - GENERAL ARTICLE, THE INTERNAL GRIEVANCE PROCESS ESTABLISHED BY A CARRIER SHALL:

(I) INCLUDE AN EXPEDITED PROCEDURE FOR USE IN AN EMERGENCY CASE TO RENDER A DECISION WITHIN 24 HOURS;

(II) RESULT IN A FINAL DECISION WITHIN 60 DAYS AFTER A MEMBER FIRST CONTACTS THE CARRIER ABOUT THE ADVERSE DECISION, UNLESS:

1. THE CASE IS AN EMERGENCY CASE UNDER ITEM (I) OF THIS PARAGRAPH; OR

2. THE MEMBER AGREES TO AN EXTENSION; AND

(III) ALLOW A GRIEVANCE TO BE FILED ON BEHALF OF A MEMBER BY A PERSON WHO IS LICENSED OR CERTIFIED TO PRACTICE A HEALTH OCCUPATION IN THE STATE.

(C) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, A MEMBER SHALL EXHAUST THE CARRIER'S INTERNAL GRIEVANCE PROCESS PRIOR TO FILING A COMPLAINT WITH THE COMMISSIONER.

(D) A MEMBER MAY TRANSFER A COMPLAINT TO THE COMMISSIONER UPON A DETERMINATION BY THE COMMISSIONER OF GOOD CAUSE.

(E) EACH CARRIER SHALL:

(1) FILE WITH THE COMMISSIONER AND THE HEALTH ADVOCACY UNIT A COPY OF ITS INTERNAL GRIEVANCE PROCESS; AND

(2) UPDATE THE INITIAL FILING ANNUALLY TO REFLECT ANY CHANGES

MADE.

(F) EXCEPT FOR AN EMERGENCY CASE UNDER SUBSECTION (B)(2)(II) OF THIS SECTION, AT THE TIME THAT A MEMBER CONTACTS THE CARRIER CONCERNING AN ADVERSE DECISION, THE CARRIER SHALL ADVISE THE MEMBER IN WRITING:

(1) ABOUT THE DETAILS OF ITS INTERNAL GRIEVANCE PROCESS;

(2) THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO ASSIST THE MEMBER WITH FILING A GRIEVANCE UNDER THE CARRIER'S INTERNAL GRIEVANCE PROCESS;

(3) THAT THE HEALTH ADVOCACY UNIT OFFERS A MEDIATION SERVICE THAT MAY ASSIST THE MEMBER;

(4) OF THE ADDRESS, TELEPHONE NUMBER, FACSIMILE NUMBER, AND E-MAIL ADDRESS OF THE HEALTH ADVOCACY UNIT;

(5) THAT THE MEMBER MAY TRANSFER THE COMPLAINT TO THE MARYLAND INSURANCE COMMISSIONER UPON A DETERMINATION BY THE COMMISSIONER OF GOOD CAUSE;

(6) OF THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER, AND FACSIMILE NUMBER; AND

(7) WHERE THE INFORMATION REQUIRED BY THIS SUBSECTION CAN BE FOUND IN THE MEMBER’S POLICY, CERTIFICATE, ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE.

(G) (1) THE CARRIER’S INTERNAL GRIEVANCE PROCESS SHALL REQUIRE ANY GRIEVANCE DECISION TO BE DOCUMENTED IN WRITING AND SENT TO THE MEMBER.

(2) THE NOTICE OF A GRIEVANCE DECISION SHALL:

(I) STATE THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S ADVERSE DECISION AND GRIEVANCE DECISION;

(II) REFERENCE THE SPECIFIC CRITERIA AND STANDARDS, INCLUDING INTERPRETIVE GUIDELINES, ON WHICH THE ADVERSE DECISION AND GRIEVANCE DECISION ARE BASED; AND

(III) PROVIDE THE FOLLOWING INFORMATION:

1. THE RIGHT OF THE MEMBER TO FILE A COMPLAINT WITH THE COMMISSIONER; AND

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

(3) GENERALIZED TERMS, INCLUDING TERMS SUCH AS "EXPERIMENTAL PROCEDURE NOT COVERED", "COSMETIC PROCEDURE NOT COVERED", "SERVICES INCLUDED UNDER ANOTHER PROCEDURE", OR "NOT MEDICALLY NECESSARY", SHALL NOT BE SUFFICIENT TO SATISFY THE REQUIREMENTS OF PARAGRAPH (2)(I) OR (II) OF THIS SUBSECTION.

(H) EACH CARRIER SHALL INCLUDE THE INFORMATION REQUIRED BY SUBSECTIONS (F) AND (G) (2)(III) OF THIS SECTION IN THE POLICY, CERTIFICATE, ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE PROVIDED TO A MEMBER AT THE TIME OF THE MEMBER'S INITIAL COVERAGE UNDER THE POLICY OR PLAN ISSUED BY THE CARRIER.

(I) THIS SECTION DOES NOT LIMIT THE RIGHT OF ANY MEMBER TO:

(1) FILE A COMPLAINT WITH THE COMMISSIONER UNDER ANY OTHER PROVISION OF THIS ARTICLE; OR

(2) CONTACT THE HEALTH ADVOCACY UNIT FOR ASSISTANCE WITH AN ADVERSE DECISION.

(J) THE HEALTH ADVOCACY UNIT SHALL IMMEDIATELY REFER TO THE COMMISSIONER ANY MEMBER WHO WISHES TO FILE A COMPLAINT WITH THE COMMISSIONER.

(K) IF A MEMBER FILES A COMPLAINT WITH THE COMMISSIONER AFTER THE HEALTH ADVOCACY UNIT HAS ATTEMPTED TO ASSIST THE MEMBER, THE HEALTH ADVOCACY UNIT SHALL IMMEDIATELY TRANSMIT TO THE COMMISSIONER A COPY OF ALL RELEVANT INFORMATION AND DOCUMENTS OBTAINED BY THE HEALTH ADVOCACY UNIT.

(L) THE HEALTH ADVOCACY UNIT SHALL ESTABLISH A TOLL-FREE TELEPHONE NUMBER THAT CAN BE USED BY MEMBERS TO CONTACT THE UNIT.

15-1403.

(A) THE COMMISSIONER MAY REQUEST A CONSENT FORM TO BE SIGNED BY THE MEMBER AUTHORIZING THE RELEASE OF THE MEMBER'S MEDICAL RECORDS FOR THE PURPOSE OF DECIDING THE COMPLAINT.

(B) (1) DURING THE REVIEW BY THE COMMISSIONER, THE CARRIER SHALL HAVE THE BURDEN OF PERSUASION THAT ITS ADVERSE DECISION OR GRIEVANCE DECISION IS CORRECT.

(2) A CARRIER SHALL NOT MEET ITS BURDEN OF PERSUASION IF ITS ADVERSE DECISION RELIES ON CONCLUSORY TERMS SUCH AS “EXPERIMENTAL PROCEDURE NOT COVERED”, “COSMETIC PROCEDURE NOT COVERED”, “SERVICES INCLUDED UNDER ANOTHER PROCEDURE”, OR “NOT MEDICALLY NECESSARY”.

(3) THE ADVERSE DECISION MUST STATE IN CLEAR, UNDERSTANDABLE LANGUAGE THE FACTUAL BASES FOR THE DECISION AND REFERENCE THE SPECIFIC CRITERIA AND STANDARDS, INCLUDING INTERPRETIVE GUIDELINES, ON WHICH THE

ADVERSE DECISION IS BASED.

(4) A CARRIER MAY NOT RELY ON ANY BASIS NOT STATED IN ITS ADVERSE DECISION OR GRIEVANCE DECISION.

(C) IN APPROPRIATE CASES, THE COMMISSIONER:

(1) MAY REFER A CASE TO AN ADVISORY COMMITTEE FOR ADVICE ABOUT MEDICAL ISSUES RELATED TO ADVERSE DECISIONS OR GRIEVANCE DECISIONS; AND

(2) WITHOUT CONVENING AN ADVISORY COMMITTEE, MAY SEEK THE ADVICE OF IMPARTIAL HEALTH CARE PROFESSIONALS.

(D) ANY ADVISORY COMMITTEE MEMBER TO WHOM THE COMMISSIONER REFERS A CASE OR IMPARTIAL HEALTH CARE PROFESSIONAL WITH WHOM THE COMMISSIONER CONSULTS SHALL HAVE NO DIRECT FINANCIAL INTEREST IN OR CONNECTION TO THE CASE PENDING BEFORE THE COMMISSIONER.

(E) THE COMMISSIONER SHALL:

(1) MAKE A DETERMINATION OF ALL COMPLAINTS WITHIN THE COMMISSIONER'S JURISDICTION;

(2) ISSUE A WRITTEN DECISION ON ALL COMPLAINTS WITHIN THE COMMISSIONER'S JURISDICTION;

(3) IF THE COMMISSIONER DETERMINES A CARRIER IMPROPERLY DENIED MEDICALLY NECESSARY COVERED BENEFITS, THE COMMISSIONER MAY ORDER THE CARRIER TO MAKE PAYMENT; AND

(4) ADVISE ALL PARTIES OF THE OPPORTUNITY AND TIME PERIOD FOR REQUESTING A HEARING TO BE HELD IN ACCORDANCE WITH TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE, TO CONTEST THE DECISION OF THE

COMMISSIONER ISSUED UNDER PARAGRAPH (2) OF THIS SUBSECTION.

(F) THE COMMISSIONER MAY REFER ANY MEMBER COMPLAINTS NOT WITHIN THE COMMISSIONER'S JURISDICTION TO ANY APPROPRIATE GOVERNMENT AGENCY FOR DISPOSITION OR RESOLUTION.

15-1404.

(A) ON A QUARTERLY BASIS, THE HEALTH ADVOCACY UNIT SHALL SUBMIT A REPORT TO THE COMMISSIONER THAT:

(1) DESCRIBES ACTIVITIES OF THE UNIT ON BEHALF OF THE MEMBERS WHO HAVE PARTICIPATED IN AN INTERNAL GRIEVANCE PROCESS OF A CARRIER UNDER THIS SUBTITLE;

(2) DESCRIBES EFFORTS OF THE UNIT TO MEDIATE IN EACH CASE INVOLVING AN ADVERSE DECISION;

(3) NAMES EACH CARRIER INVOLVED IN EACH CASE DESCRIBED IN THE REPORT;

(4) STATES THE NUMBER AND RESULTS IN EACH CASE CONSIDERED AN EMERGENCY CASE UNDER § 15-1402(B)(2)(I) OF THIS SUBTITLE DESCRIBED IN THE REPORT, INCLUDING THE TIME WITHIN WHICH THE GRIEVANCE WAS COMPLETED FOR EACH EMERGENCY CASE; AND

(5) STATES THE NUMBER AND RESULTS IN EACH CASE DESCRIBED IN THE REPORT INCLUDING THE TIME WITHIN WHICH THE GRIEVANCE WAS COMPLETED FOR EACH CASE.

(B) (1) THE HEALTH ADVOCACY UNIT SHALL PREPARE AN ANNUAL REPORT ON ALL COMPLAINTS AND APPEALS FILED UNDER THIS SUBTITLE DURING THE PREVIOUS FISCAL YEAR WITH THE COMMISSIONER, THE HEALTH ADVOCACY UNIT, OR ANY OTHER GOVERNMENT AGENCY.

(2) THE HEALTH ADVOCACY UNIT SHALL PUBLISH THE REPORT BY NOVEMBER 15 OF EACH YEAR BEGINNING IN 1998 AND PROVIDE COPIES TO THE LEGISLATIVE POLICY COMMITTEE, THE SENATE FINANCE COMMITTEE, THE HOUSE ECONOMIC MATTERS COMMITTEE, AND THE HOUSE ENVIRONMENTAL MATTERS COMMITTEE.

(3) IN CONSULTATION WITH THE COMMISSIONER AND ANY AFFECTED GOVERNMENT AGENCY, THE HEALTH ADVOCACY UNIT, IN ITS ANNUAL REPORT, SHALL EVALUATE THE EFFECTIVENESS OF THE COMPLAINT AND APPEAL PROCESS AVAILABLE TO MEMBERS AND PROPOSE CHANGES DEEMED NECESSARY.

15-1405.

ON A QUARTERLY BASIS, EACH CARRIER SHALL SUBMIT A REPORT TO THE COMMISSIONER THAT DESCRIBES ACTIVITIES OF THE CARRIER UNDER THIS SUBTITLE, INCLUDING:

(1) EFFORTS AT MEDIATION ON ADVERSE DECISIONS;

(2) THE NUMBER AND RESULTS OF EACH CASE THAT IS CONSIDERED AN EMERGENCY CASE UNDER § 15-1402(B)(2)(I) OF THIS SUBTITLE, INCLUDING THE TIME WITHIN WHICH THE GRIEVANCE WAS COMPLETED FOR EACH EMERGENCY CASE; AND

(3) THE NUMBER AND RESULTS IN EACH CASE, INCLUDING THE TIME WITHIN WHICH THE CARRIER COMPLETED ITS INTERNAL GRIEVANCE PROCESS FOR EACH CASE.

27-304.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer or nonprofit health service plan, when committed with the frequency to indicate a general business

(Over)

practice, to:

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

(2) fail to acknowledge and act with reasonable promptness on communications about claims that arise under policies;

(3) fail to adopt and implement reasonable standards for the prompt investigation of claims that arise under policies;

(4) refuse to pay a claim without conducting a reasonable investigation based on all available information;

(5) fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) fail to make a prompt, fair, and equitable good faith attempt, to settle claims for which liability has become reasonably clear;

(7) compel insureds to institute litigation to recover amounts due under policies by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempt to settle a claim for less than the amount to which a reasonable person would expect to be entitled after studying written or printed advertising material accompanying, or made part of, an application;

(9) attempt to settle a claim based on an application that is altered without notice to, or the knowledge or consent of, the insured;

(10) fail to include with each claim paid to an insured or beneficiary a statement of the coverage under which the payment is being made;

(11) make known to insureds or claimants a policy of appealing from arbitration

awards in order to compel insureds or claimants to accept a settlement or compromise less than the amount awarded in arbitration;

(12) delay an investigation or payment of a claim by requiring a claimant or a claimant's licensed health care provider to submit a preliminary claim report and subsequently to submit formal proof of loss forms that contain substantially the same information;

(13) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy, in order to influence settlements under other parts of the policy;

(14) fail to provide promptly a reasonable explanation of the basis for denial of a claim or the offer of a compromise settlement; [or]

(15) fail to meet the requirements of Title 19, Subtitle 13 of the Health - General Article for preauthorization for a health care service; OR

(16) IMPROPERLY FAIL TO REIMBURSE FOR MEDICALLY NECESSARY COVERED BENEFITS.".

AMENDMENT NO. 5

On page 13, in line 4, after "to" insert "provisions enacted by Section 1 of this Act regarding: (1)"; in line 5, strike "15-1406" and substitute "15-1404"; in lines 5 and 6, strike ", as enacted by Section 1 of this Act" and substitute "; and (2) funding from the Maryland Insurance Administration for the activities of the Unit required under §§ 15-1402 and 15-1404 of the Insurance Article"; strike in their entirety lines 18 through 21, inclusive; in line 22, strike "5." and substitute "4."; after line 23 insert:

"SECTION 5. AND BE IT FURTHER ENACTED, That the Maryland Insurance Administration, as part of the annual report required under §15-1404 of the Insurance Article, shall report the number of complaints filed against carriers related to a hospital length of stay or a requirement to have a service performed on an outpatient basis, and the extent to which the complaints are related to a certain practice guideline.

SECTION 6. AND BE IT FURTHER ENACTED, That Section 5 of this Act shall remain effective for a period of 2 years and, at the end of January 1, 2000, with no further action required by the General Assembly, Section 5 of this Act shall be abrogated and of no further force and effect."; in line 24, strike "6." and substitute "7."; in line 25, strike "5" and substitute "4"; and in the same line, strike "October 1, 1997" and substitute "January 1, 1998".