BY: Conference Committee

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

AMENDMENT NO. 1

On page 1, strike in their entirety lines 2 and 3 and substitute "Health Insurance - Complaint Process for Adverse Decisions and Grievances"; in lines 4 and 5, and line 6, in each instance, strike "complaint and review" and substitute "grievances"; and in line 20, strike "and appeals".

On page 2, strike beginning with "making" in line 3 down through "practice" in line 4 and substitute "providing that the failure of an insurer or nonprofit health service plan to reimburse for medically necessary covered benefits is an unfair claim settlement practice"; in line 9, after "Act;" inSert "providing for the termination of certain provisions of this Act;"; in line 10, strike "complaints and appeals about health care benefits" and substitute "a carrier's complaint process for adverse decisions or grievances in health insurance"; and in line 27 and 28, strike "Adverse Decisions Involving Health Benefit Plans" and substitute "Complaint Process for Adverse Decisions or Grievances".

On page 2, in line 34, strike "27-303" and substitute "27-304".

AMENDMENT NO. 2

On page 3, strike line 31 and substitute "COMPLAINT PROCESS FOR ADVERSE DECISIONS OR GRIEVANCES"; in line 36, after "A", insert "UTILIZATION REVIEW". On page 4, strike beginning with the first "OR" in line 1 down through the period in line 9, and substitute ", A CARRIER, OR A PROVIDER WHO IS LICENSED TO PRACTICE A HEALTH OCCUPATION IN THE STATE WHO IS 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.";

after line 20, insert:

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

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

in line 21, strike "(D)" and substitute "(F)"; and in line 29, strike "(E)" and substitute "(G)".

AMENDMENT NO. 3

On page 4, after line 32, insert:

"(A) THE COMMISSIONER SHALL ADOPT REGULATIONS TO CARRY OUT THIS SUBTITLE."; and

in line 33, strike "(A)" and substitute "(B)". On page 5, in lines 10 and 14, strike "(B)" and "(C)", respectively, and substitute "(C)" and "(D)", respectively.

AMENDMENT NO. 4

On page 5, in line 34, before the colon insert "SHALL"; and in line 35, strike "SHALL". On pages 5 and 6, strike in their entirety the lines beginning with line 37 on page 5 through line 3 on page 6, and substitute:

"(II) RESULT IN A FINAL DECISION WITHIN 30 WORKING DAYS AFTER THE DAY ON WHICH A MEMBER FILES A GRIEVANCE UNLESS:

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

2. THE MEMBER AGREES TO AN EXTENSION; AND".

On page 6, in line 4, strike "(IV)" and substitute "(III)"; strike "SHALL"; and strike beginning with the semicolon in line 6 down through "DECISIONS" in line 9.

On page 6, after line 9, insert:

"(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 FILE A COMPLAINT WITH THE COMMISSIONER IF THE MEMBER SHOWS A COMPELLING REASON TO DO SO.".

On page 6, in line 10, strike "(C)" and substitute "(E)".

AMENDMENT NO. 5

On page 6 , in line 23, strike "OR URGENT"; in line 24, strike "OR (II)"; and in the same line, strike "WITHIN 24 HOURS AFTER" and substitute "AT THE TIME".

AMENDMENT NO. 6

On page 7, strike in their entirety lines 17 through 20, inclusive and substitute :

"(G)(1) THE CARRIER'S INTERNAL GRIEVANCE PROCESS SHALL REQUIRE ANY ADVERSE DECISION OR GRIEVANCE DECISION TO BE DOCUMENTED IN WRITING AND SENT TO THE MEMBER AND, IF THE GRIEVANCE WAS FILED ON BEHALF OF THE MEMBER UNDER SUBSECTION (B)(2)(IV) OF THIS SECTION, TO THE PERSON WHO FILED THE GRIEVANCE.";

and in line 21, after "DECISION" insert "OR GRIEVANCE DECISION".

AMENDMENT NO. 7

On page 8, in line 9, strike "EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION,"; strike in their entirety lines 14 through 18; in line 19, strike "(3)" and substitute "(2)"; strike beginning with "SHALL" in line 23 down through "(III)" in line 25; in line 25, strike " OR URGENT"; in line 26, strike "OR (II)"; and in line 37, strike "(4)" and substitute "(3)".

AMENDMENT NO. 8

(Over)

On pages 10 and 11, strike in their entirety the lines beginning with line 21 on page 10 through line 6 on page 11 and substitute:

"15-1406.

(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.".

AMENDMENT NO. 9

On page 11, strike in their entirety lines 7 through 28, inclusive, and substitute:

"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 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;

(Over)

(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. 10

On page 13, strike in their entirety lines 1 through 25, inclusive, and substitute:

"SECTION 2. AND BE IT FURTHER ENACTED, That the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General and the Maryland Insurance Commissioner shall enter into a Memorandum of Understanding by October 1, 1997, with respect to provisions enacted by Section 1 of this Act regarding: (1) the format and contents of the annual report required under § 15-1406 of the Insurance Article; 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.

SECTION 3. AND BE IT FURTHER ENACTED, That the Health Education and Advocacy Unit, in conjunction with other affected units of State government, shall study and make recommendations to the Legislative Policy Committee, the Senate Finance Committee, the House Economic Matters Committee, and the House Environmental Matters Committee by October 1, 1998, about the feasibility and advisability of:

(1) transferring all or some of the responsibilities of the Department of Health and Mental Hygiene with respect to utilization review and private review agents to the Maryland Insurance Administration; and

(2) requiring all carriers to have a uniform complaint and review process for members in accordance with regulations issued by the Maryland Insurance Commissioner.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect June 1, 1997.

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.

(Over)

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.

SECTION 7. AND BE IT FURTHER ENACTED, That, except as provided in Section 4 of this Act, this Act shall take effect January 1, 1998. " .