
By: Delegates Donoghue, Love, Snodgrass, Klausmeier, Hammen, Morhaim, Boston, Kirk, Faulkner, Bonsack, McHale, Stull, V. Mitchell, Edwards, Frank, Weir, Barve, Shriver, Mossburg, Exum, Krysiak, Poole, Hecht, Elliott, Workman, Pendergrass, Fulton, Gordon, Eckardt, McClenahan, Harrison, McKee, Stup, Walkup, Fry, and Mohorovic

Introduced and read first time: January 31, 1997

Assigned to: Economic Matters

A BILL ENTITLED

1 AN ACT concerning

2 Health Insurance - Health Care Benefits Complaint and Appeal Process

3 FOR the purpose of requiring a carrier to establish a certain internal complaint and
4 review process for members; requiring a carrier to file a copy of its internal
5 complaint and review process with the Maryland Insurance Commissioner and the
6 Health Education and Advocacy Unit in the Division of Consumer Protection of the
7 Office of the Attorney General and to update the initial filing annually; requiring a
8 carrier to provide certain information to a member at the time the member initiates
9 a complaint under the carrier's complaint and review process; requiring a carrier to
10 send a member written notice of an adverse decision and specifying the contents of
11 the notice; requiring a carrier to include certain information in a policy, certificate,
12 enrollment materials, or other evidence of coverage provided to a member at a
13 certain time; requiring certain complaints or appeals filed by members with the
14 Commissioner to be in a certain form; providing that a carrier has the burden of
15 persuasion that its adverse decision is correct during review by the Commissioner;
16 authorizing the Commissioner to utilize physicians and certain persons that practice
17 a health occupation to advise the Commissioner on certain medical issues; requiring
18 the Commissioner to make a determination of and issue a written decision on all
19 complaints and appeals within the Commissioner's jurisdiction; authorizing the
20 Commissioner to refer other complaints and appeals to the Health Education and
21 Advocacy Unit or an appropriate government agency; requiring the Health
22 Education and Advocacy Unit to prepare and publish a certain report and provide
23 copies of the report to certain committees of the General Assembly; providing that
24 the failure of an insurer or nonprofit health service plan to reimburse for medically
25 necessary covered benefits is an unfair claim settlement practice; requiring the
26 Health Education and Advocacy Unit and the Commissioner to enter into a certain
27 Memorandum of Understanding by a certain date; requiring the Health Education
28 and Advocacy Unit to make certain recommendations to certain committees of the
29 General Assembly by a certain date; providing for the effect of certain provisions of
30 this Act; defining certain terms; providing for the effective dates of this Act; and
31 generally relating to complaints and appeals about health care benefits.

32 BY adding to

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1 Article - Health - General
2 Section 19-706(n)
3 Annotated Code of Maryland
4 (1996 Replacement Volume and 1996 Supplement)

5 BY adding to

6 Article - Insurance
7 Section 2-104(k)
8 Annotated Code of Maryland
9 (1995 Volume and 1996 Supplement)
10 (As enacted by Chapter 36 of the Acts of the General Assembly of 1995, as
11 amended by Chapter 352 of the Acts of the General Assembly of 1995, as
12 amended by Chapter 271 of the Acts of the General Assembly of 1996)

13 BY adding to

14 Article - Insurance
15 Section 15-1401 through 15-1404, inclusive, to be under the new subtitle "Subtitle
16 14. Health Care Benefits Complaint and Appeal Process"
17 Annotated Code of Maryland
18 (1995 Volume and 1996 Supplement)
19 (As enacted by Chapter ____ (H.B. 11) of the Acts of the General Assembly of 1997)

20 BY repealing and reenacting, with amendments,

21 Article - Insurance
22 Section 27-303 and 27-304
23 Annotated Code of Maryland
24 (1995 Volume and 1996 Supplement)
25 (As enacted by Chapter ____ (H.B. 11) of the Acts of the General Assembly of 1997)

26 Preamble

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

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

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

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

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

3 **Article - Health - General**

4 19-706.

5 (N) THE PROVISIONS OF TITLE 15, SUBTITLE 14 OF THE INSURANCE ARTICLE
6 SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

7 **Article - Insurance**

8 2-104.

9 (K) THE COMMISSIONER MAY UTILIZE PHYSICIANS OR PERSONS THAT ARE
10 LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO PRACTICE A HEALTH
11 OCCUPATION IN THIS STATE OR ANY OTHER STATE, TO ADVISE THE COMMISSIONER
12 ON MEDICAL ISSUES RELATED TO COMPLAINTS OR APPEALS FILED WITH RESPECT
13 TO HEALTH BENEFITS UNDER TITLE 15, SUBTITLE 14 OR TITLE 27 OF THIS ARTICLE.

14 SUBTITLE 14. HEALTH CARE BENEFITS COMPLAINT AND APPEAL PROCESS.

15 15-1401.

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

18 (B) "ADVERSE DECISION" HAS THE MEANING STATED IN § 19-1301 OF THE
19 HEALTH - GENERAL ARTICLE.

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

24 (D) "CARRIER" MEANS:

25 (1) AN INSURER;

26 (2) A NONPROFIT HEALTH SERVICE PLAN;

27 (3) A HEALTH MAINTENANCE ORGANIZATION;

28 (4) A DENTAL PLAN ORGANIZATION; OR

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

31 (E) "HEALTH ADVOCACY UNIT" MEANS THE HEALTH EDUCATION AND
32 ADVOCACY UNIT IN THE DIVISION OF CONSUMER PROTECTION OF THE OFFICE OF
33 THE ATTORNEY GENERAL.

34 (F) (1) "MEMBER" MEANS A PERSON OR A PERSON'S AUTHORIZED
35 REPRESENTATIVE, INCLUDING ANY PERSON LICENSED, CERTIFIED, OR OTHERWISE
36 AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE OR THE HEALTH -

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1 GENERAL ARTICLE, THAT IS ENTITLED TO HEALTH BENEFITS OR REIMBURSEMENT
2 UNDER A POLICY OR PLAN ISSUED OR DELIVERED IN THE STATE BY A CARRIER.

3 (2) "MEMBER" INCLUDES A SUBSCRIBER.

4 15-1402.

5 (A) EACH CARRIER SHALL ESTABLISH AN INTERNAL COMPLAINT AND
6 REVIEW PROCESS FOR MEMBERS WHICH, AT A MINIMUM, COMPLIES WITH THE
7 REQUIREMENTS OF TITLE 19, SUBTITLE 13 OF THE HEALTH - GENERAL ARTICLE,
8 INCLUDING:

9 (1) TIME FRAMES AND PROCEDURES FOR MAKING DECISIONS ON
10 WHETHER TO APPROVE OR PREAUTHORIZE A PROPOSED OR DELIVERED HEALTH
11 CARE SERVICE;

12 (2) TIME FRAMES AND PROCEDURES FOR RECONSIDERATIONS OR
13 APPEALS OF ADVERSE DECISIONS;

14 (3) QUALIFICATIONS OF PERSONS EMPLOYED BY OR UNDER CONTRACT
15 WITH THE CARRIER TO PERFORM UTILIZATION REVIEW; AND

16 (4) QUALIFICATIONS OF PERSONS MAKING ADVERSE DECISIONS.

17 (B) EACH CARRIER SHALL:

18 (1) FILE WITH THE COMMISSIONER AND THE HEALTH ADVOCACY UNIT
19 A COPY OF ITS INTERNAL COMPLAINT AND REVIEW PROCESS; AND

20 (2) UPDATE THE INITIAL FILING ANNUALLY TO REFLECT ANY CHANGES
21 MADE.

22 (C) AT THE TIME THAT A MEMBER INITIATES A COMPLAINT UNDER A
23 CARRIER'S INTERNAL COMPLAINT AND REVIEW PROCESS, THE CARRIER SHALL
24 ADVISE THE MEMBER ABOUT THE DETAILS OF ITS INTERNAL COMPLAINT AND
25 REVIEW PROCESS AND OF THE FOLLOWING:

26 (1) THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO ASSIST THE
27 MEMBER WITH FILING THE COMPLAINT UNDER THE CARRIER'S INTERNAL
28 COMPLAINT AND REVIEW PROCESS;

29 (2) THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO ASSIST THE
30 MEMBER IN MEDIATING A RESOLUTION OF THE MEMBER'S COMPLAINT WITH THE
31 CARRIER;

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

34 (4) WHERE THE INFORMATION REQUIRED BY THIS SUBSECTION CAN BE
35 FOUND IN THE MEMBER'S POLICY, CERTIFICATE, ENROLLMENT MATERIALS, OR
36 OTHER EVIDENCE OF COVERAGE.

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1 (D) (1) THE CARRIER'S INTERNAL COMPLAINT AND REVIEW PROCESS
2 SHALL REQUIRE ANY ADVERSE DECISION TO BE DOCUMENTED IN WRITING AND
3 SENT TO THE MEMBER.

4 (2) THE NOTICE OF AN ADVERSE DECISION SHALL:

5 (I) STATE THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S
6 DECISION;

7 (II) REFERENCE THE SPECIFIC CRITERIA AND STANDARDS,
8 INCLUDING INTERPRETIVE GUIDELINES, ON WHICH THE ADVERSE DECISION IS
9 BASED; AND

10 (III) PROVIDE THE FOLLOWING INFORMATION:

11 1. THE RIGHT OF THE MEMBER TO FILE AN APPEAL WITH
12 THE COMMISSIONER; AND

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

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

20 (E) EACH CARRIER SHALL INCLUDE THE INFORMATION REQUIRED BY
21 SUBSECTIONS (C) AND (D)(2)(III) OF THIS SECTION IN THE POLICY, CERTIFICATE,
22 ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE PROVIDED TO A
23 MEMBER AT THE TIME OF THE MEMBER'S INITIAL COVERAGE UNDER THE POLICY
24 OR PLAN ISSUED BY THE CARRIER.

25 (F) THIS SECTION DOES NOT LIMIT THE RIGHT OF ANY MEMBER TO FILE A
26 COMPLAINT:

27 (1) WITH THE COMMISSIONER UNDER ANY OTHER PROVISION OF THIS
28 ARTICLE; OR

29 (2) WITH THE HEALTH ADVOCACY UNIT.

30 15-1403.

31 (A) (1) ANY COMPLAINT RELATING TO THE DENIAL OF MEDICALLY
32 NECESSARY COVERED BENEFITS OR PAYMENT FOR MEDICALLY NECESSARY
33 COVERED BENEFITS OR ANY APPEAL OF AN ADVERSE DECISION FILED BY A
34 MEMBER WITH THE COMMISSIONER SHALL BE IN THE FORM PRESCRIBED BY THE
35 COMMISSIONER.

36 (2) THE FORM SHALL INCLUDE A CONSENT FORM TO BE SIGNED BY THE
37 MEMBER AUTHORIZING THE RELEASE OF THE MEMBER'S MEDICAL RECORDS FOR
38 THE PURPOSE OF DECIDING THE COMPLAINT OR APPEAL.

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

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

7 (3) THE ADVERSE DECISION MUST STATE IN CLEAR, UNDERSTANDABLE
8 LANGUAGE THE FACTUAL BASES FOR THE DECISION AND REFERENCE THE SPECIFIC
9 CRITERIA AND STANDARDS, INCLUDING INTERPRETIVE GUIDELINES, ON WHICH
10 THE ADVERSE DECISION IS BASED.

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

13 (C) IN APPROPRIATE CASES, THE COMMISSIONER:

14 (1) MAY REFER A CASE TO AN ADVISORY COMMITTEE FOR ADVICE
15 ABOUT MEDICAL ISSUES; AND

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

18 (D) THE COMMISSIONER SHALL:

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

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

23 (3) ADVISE ALL PARTIES OF ANY APPLICABLE PROVISIONS OF TITLE 10,
24 SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE.

25 (E) THE COMMISSIONER MAY REFER ANY MEMBER COMPLAINTS AND
26 APPEALS NOT WITHIN THE COMMISSIONER'S JURISDICTION TO THE HEALTH
27 ADVOCACY UNIT OR ANY APPROPRIATE GOVERNMENT AGENCY FOR DISPOSITION
28 OR RESOLUTION.

29 15-1404.

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

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

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

5 27-303.

6 It is an unfair claim settlement practice and a violation of this subtitle for an insurer
7 or nonprofit health service plan to:

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

10 (2) refuse to pay a claim for an arbitrary or capricious reason based on all
11 available information;

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

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

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

19 (6) fail to provide promptly on request a reasonable explanation of the basis
20 for a denial of a claim; [or]

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

23 (8) FAIL TO REIMBURSE FOR MEDICALLY NECESSARY COVERED
24 BENEFITS.

25 27-304.

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

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

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

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

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

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

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

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

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

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

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

13 (11) make known to insureds or claimants a policy of appealing from
14 arbitration awards in order to compel insureds or claimants to accept a settlement or
15 compromise less than the amount awarded in arbitration;

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

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

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

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

27 (16) FAIL TO REIMBURSE FOR MEDICALLY NECESSARY COVERED
28 BENEFITS.

29 SECTION 2. AND BE IT FURTHER ENACTED, That the Health Education and
30 Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney
31 General and the Maryland Insurance Commissioner shall enter into a Memorandum of
32 Understanding by October 1, 1997, with respect to the format and contents of the annual
33 report required under § 15-1404 of the Insurance Article, as enacted by Section 1 of this
34 Act.

35 SECTION 3. AND BE IT FURTHER ENACTED, That the Health Education and
36 Advocacy Unit shall study and make recommendations to the Legislative Policy
37 Committee, the Senate Finance Committee, the House Economic Matters Committee,
38 and the House Environmental Matters Committee by October 1, 1998, about the
39 feasibility and advisability of:

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

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

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

9 SECTION 5. AND BE IT FURTHER ENACTED, That, except as provided in
10 Section 4 of this Act, this Act shall take effect October 1, 1997.