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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

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 20, 1997

CHAPTER ____

AN ACT concerning

Health Insurance - Health Care Benefits ~~Complaint and Appeal Process~~ - Adverse Decisions - Grievances and Complaints

FOR the purpose of requiring a carrier to establish a certain internal complaint and review process for members; requiring a carrier to file a copy of its internal complaint and review process with the Maryland Insurance Commissioner and the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General and to update the initial filing annually; requiring a carrier to provide certain information to a member at the time the member initiates a complaint under the carrier's complaint and review process; requiring a carrier to send a member written notice of an adverse decision and specifying the contents of the notice; requiring a carrier to include certain information in a policy, certificate, enrollment materials, or other evidence of coverage provided to a member at a certain time; ~~requiring certain complaints or appeals filed by members with the Commissioner to be in a certain form;~~ providing that a carrier has the burden of persuasion that its adverse decision is correct during review by the Commissioner; authorizing the Commissioner to utilize physicians and certain persons that practice a health occupation to advise the Commissioner on certain medical issues; requiring the Commissioner to make a determination of and issue a written decision on all complaints and appeals within the Commissioner's jurisdiction; authorizing the Commissioner to issue certain orders under certain circumstances; authorizing the Commissioner to refer other complaints and appeals to the Health Education and Advocacy Unit or an appropriate government agency; requiring the Health Education and Advocacy Unit to prepare and publish a certain report and provide

copies of the report to certain committees of the General Assembly; ~~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~~ making a single instance of a certain act an unfair claim settlement practice; requiring the Health Education and Advocacy Unit and the Commissioner to enter into a certain Memorandum of Understanding by a certain date; requiring the Health Education and Advocacy Unit to make certain recommendations to certain committees of the General Assembly by a certain date; providing for the effect of certain provisions of this Act; defining certain terms; providing for the effective dates of this Act; and generally relating to complaints and appeals about health care benefits.

BY adding to
Article - Health - General
Section 19-706(n)
Annotated Code of Maryland
(1996 Replacement Volume and 1996 Supplement)

~~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 Acts 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)~~

BY adding to
Article - Insurance
Section 15-1401 through ~~15-1404~~ 15-1406, inclusive, to be under the new subtitle "Subtitle 14. ~~Health Care Benefits Complaint and Appeal Process~~ Adverse Decisions Involving Health Benefit Plans"
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of 1997)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 27-303 ~~and 27-304~~
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of 1997)

BY adding to
Article - Commercial Law
Section 13-4A-04

Annotated Code of Maryland
(1990 Replacement Volume and 1996 Supplement)

~~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,~~

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

Article - Health - General

19-706.

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

Article - Insurance

~~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 COMPLAINTS OR APPEALS FILED WITH RESPECT TO HEALTH BENEFITS UNDER TITLE 15, SUBTITLE 14 OR TITLE 27 OF THIS ARTICLE.~~

SUBTITLE 14. ~~HEALTH CARE BENEFITS COMPLAINT AND APPEAL PROCESS~~ ADVERSE DECISIONS INVOLVING HEALTH BENEFIT PLANS.

15-1401.

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

(B) (1) "ADVERSE DECISION" ~~HAS THE MEANING STATED IN § 19-1301 OF THE HEALTH - GENERAL ARTICLE~~ MEANS A DETERMINATION, MADE BY A PRIVATE

REVIEW AGENT OR CARRIER OR A PROVIDER WHO IS LICENSED TO PRACTICE A HEALTH OCCUPATION IN THE STATE, THAT:

(I) A HEALTH CARE SERVICE THAT IS PROPOSED TO BE DELIVERED IS NOT NECESSARY, APPROPRIATE, OR EFFICIENT; AND

(II) THE SERVICE IS NOT A COVERED BENEFIT.

(2) "ADVERSE DECISION" DOES NOT INCLUDE:

(I) A DECISION REACHED BY A PROVIDER IN CONJUNCTION WITH A PRIVATE REVIEW AGENT OR CARRIER ON BEHALF OF A PATIENT; OR

(II) A RETROACTIVE DECISION.

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

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

~~(F) (1) "MEMBER" MEANS A PERSON OR A PERSON'S AUTHORIZED REPRESENTATIVE, INCLUDING ANY PERSON LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE OR THE HEALTH - GENERAL ARTICLE, THAT IS ENTITLED TO HEALTH BENEFITS OR REIMBURSEMENT UNDER A POLICY OR PLAN ISSUED OR DELIVERED IN THE STATE BY A CARRIER.~~

(E) (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) THE COMMISSIONER:

(1) MAY MAKE A DECISION ON A QUESTION OF MEDICAL NECESSITY ON A COMPLAINT ABOUT AN ADVERSE DECISION FILED UNDER THIS SUBTITLE; AND

(2) MAY BASE THE DECISION ON THE ADVICE OF ONE OR MORE PERSONS:

(I) LICENSED TO PRACTICE A HEALTH OCCUPATION IN THIS STATE OR ANY OTHER STATE; AND

(II) WHO HAVE THE CAPABILITY TO GIVE ADVICE THAT IS BASED ON KNOWLEDGE OF GUIDELINES RECOMMENDED BY STATE AND FEDERAL GOVERNMENTAL AGENCIES AND NATIONALLY RECOGNIZED HEALTH CARE PROVIDER ORGANIZATIONS AND SPECIALTY SOCIETIES AND ON MEDICAL EVIDENCE THAT MEETS STANDARDS FOR SCIENTIFIC RESEARCH.

(B) TO ENSURE ACCESS TO ADVICE WHEN IT IS NEEDED, THE COMMISSIONER, IN CONSULTATION WITH THE SECRETARY OF HEALTH AND MENTAL HYGIENE SHALL ASSEMBLE A LIST OF NAMES OF MEDICAL EXPERTS THAT INCLUDES PRACTITIONERS, RESEARCHERS, AND REPRESENTATIVES OF CARRIERS.

(C) AN INDIVIDUAL WHO GIVES ADVICE TO THE COMMISSIONER MAY NOT HAVE A DIRECT FINANCIAL OR PERSONAL INTEREST IN OR CONNECTION TO THE CASE FROM WHICH THE COMPLAINT ARISES.

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

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

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

15-1403.

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

(B) (1) AN 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, AN INTERNAL GRIEVANCE PROCESS ESTABLISHED BY A CARRIER:

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

(II) SHALL INCLUDE AN EXPEDITED PROCEDURE FOR USE IN AN URGENT CASE TO RENDER A DECISION WITHIN 96 HOURS;

(III) EXCEPT FOR A CASE THAT IS AN EMERGENCY OR URGENT UNDER ITEM (I) OR (II) OF THIS PARAGRAPH, SHALL RESULT IN A FINAL DECISION,

FOR WHICH ALL INTERNAL APPEALS HAVE BEEN EXHAUSTED AND ALL EFFORTS TO MEDIATE HAVE BEEN COMPLETED, WITHIN 30 DAYS AFTER A MEMBER FIRST CONTACTS THE CARRIER ABOUT THE ADVERSE DECISION;

(IV) SHALL ALLOW A GRIEVANCE TO BE FILED ON BEHALF OF A MEMBER BY A PERSON WHO IS LICENSED TO PRACTICE A HEALTH OCCUPATION IN THE STATE; AND

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

~~(4) QUALIFICATIONS~~ OF PERSONS MAKING ADVERSE DECISIONS.

~~(B)~~ (C) EACH CARRIER SHALL:

(1) FILE WITH THE COMMISSIONER AND SUBMIT TO THE HEALTH ADVOCACY UNIT A COPY OF ITS INTERNAL ~~COMPLAINT AND REVIEW~~ GRIEVANCE PROCESS; AND

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

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

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

(D) EXCEPT FOR A CASE THAT IS AN EMERGENCY OR URGENT UNDER SUBSECTION (B)(2)(I) OR (II) OF THIS SECTION, WITHIN 24 HOURS AFTER A MEMBER FIRST CONTACTS A CARRIER ABOUT 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 OF THE OFFICE OF THE ATTORNEY GENERAL:

(I) IS AVAILABLE TO ASSIST THE MEMBER WITH FILING THE COMPLAINT UNDER THE CARRIER'S INTERNAL GRIEVANCE PROCESS; BUT

(II) IS NOT AVAILABLE TO REPRESENT OR ACCOMPANY THE MEMBER DURING THE PROCEEDINGS OF THE INTERNAL GRIEVANCE PROCESS;

~~(2)~~ (3) THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO ASSIST THE MEMBER IN MEDIATING A RESOLUTION OF THE MEMBER'S COMPLAINT WITH THE CARRIER;

~~(3)~~ (4) OF THE ADDRESS, TELEPHONE NUMBER, FACSIMILE NUMBER, AND E-MAIL ADDRESS OF THE HEALTH ADVOCACY UNIT; ~~AND~~

(5) OF THE ADDRESS, TELEPHONE NUMBER, AND FACSIMILE NUMBER OF THE COMMISSIONER; AND

~~(4)~~ (6) WHERE THE INFORMATION REQUIRED BY THIS SUBSECTION CAN BE FOUND IN THE MEMBER'S POLICY, CERTIFICATE, ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE.

(E) IF, WITHIN 5 WORKING DAYS AFTER A MEMBER FIRST CONTACTS A CARRIER ABOUT AN ADVERSE DECISION, THE CARRIER DOES NOT HAVE SUFFICIENT INFORMATION TO COMPLETE ITS INTERNAL GRIEVANCE PROCESS, THE CARRIER SHALL NOTIFY THE MEMBER AND ASSIST THE MEMBER IN GATHERING THE INFORMATION WITHOUT FURTHER DELAY.

(F) THE CARRIER MAY EXTEND THE 30-DAY PERIOD REQUIRED UNDER SUBSECTION (B)(2)(III) OF THIS SECTION WITH THE WRITTEN CONSENT OF THE MEMBER.

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

(G) (1) ANY DECISION RESULTING FROM THE INTERNAL GRIEVANCE PROCESS OF A CARRIER SHALL BE SENT IN WRITING 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.

(2) THE NOTICE OF AN ADVERSE DECISION SHALL:

(I) STATE IN DETAIL THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION;

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

(III) PROVIDE THE FOLLOWING INFORMATION:

1. THE RIGHT OF THE MEMBER TO FILE ~~AN APPEAL~~ A COMPLAINT WITH THE COMMISSIONER WITHIN 30 DAYS AFTER RECEIPT OF A FINAL DECISION RESULTING FROM AN INTERNAL GRIEVANCE PROCESS; 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.~~

~~(E)~~ (H) EACH CARRIER SHALL INCLUDE THE INFORMATION REQUIRED BY SUBSECTIONS ~~(C) AND (D)(2)(III)~~ (D) 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.

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

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

~~(2) WITH THE HEALTH ADVOCACY UNIT.~~

~~15-1403.~~ 15-1404.

(A) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, WITHIN 30 DAYS AFTER RECEIPT OF A FINAL DECISION RESULTING FROM AN INTERNAL GRIEVANCE PROCESS, A COMPLAINT MAY BE FILED WITH THE COMMISSIONER BY A MEMBER OR BY A PERSON WHO FILED THE GRIEVANCE ON BEHALF OF THE MEMBER UNDER § 15-403(B)(2)(IV) OF THIS SUBTITLE.

(2) IF A CARRIER FAILS TO SATISFY THE REQUIREMENTS OF § 15-1403(E) OF THIS SUBTITLE, THE MEMBER OR PERSON WHO FILED THE GRIEVANCE ON BEHALF OF THE MEMBER UNDER § 15-1403(B)(2)(IV) MAY FILE A COMPLAINT WITH THE COMMISSIONER BEFORE THE CARRIER REACHES A FINAL DECISION RESULTING FROM THE INTERNAL GRIEVANCE PROCESS.

(3) IN ADDITION TO THE USE OF OTHER APPROPRIATE PROCEDURES FOR INVESTIGATION OF A COMPLAINT, THE COMMISSIONER:

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

(II) SHALL INCLUDE AN EXPEDITED PROCEDURE FOR USE IN AN URGENT CASE TO RENDER A DECISION WITHIN 96 HOURS;

(III) EXCEPT FOR A CASE THAT IS AN EMERGENCY OR URGENT UNDER ITEM (I) OR (II) OF THIS PARAGRAPH, SHALL MAKE A DECISION WITHIN 30 DAYS AFTER A COMPLAINT IS FILED; AND

(IV) ALLOW A COMPLAINT TO BE FILED ON BEHALF OF A MEMBER BY A PERSON WHO IS LICENSED TO PRACTICE A HEALTH OCCUPATION IN THE STATE.

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

~~(2) THE FORM SHALL INCLUDE~~

(4) 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 ~~OR APPEAL~~.

(B) (1) DURING THE REVIEW OF THE COMPLAINT BY THE COMMISSIONER, THE CARRIER SHALL HAVE THE BURDEN OF PERSUASION THAT ITS ADVERSE 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)~~ (2) THE ADVERSE DECISION MUST STATE IN DETAIL 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)~~ (3) ~~A~~ IN RESPONSE TO A COMPLAINT, A CARRIER MAY NOT RELY ON ANY BASIS NOT STATED IN ITS ADVERSE DECISION.

(C) IN APPROPRIATE CASES, THE COMMISSIONER~~:~~

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

~~(2) WITHOUT CONVENING AN ADVISORY COMMITTEE, MAY SEEK THE ADVICE OF IMPARTIAL HEALTH CARE PROFESSIONALS.~~ MAY SEEK ADVICE OF ONE OR MORE EXPERTS ON QUESTIONS OF MEDICAL NECESSITY IN ACCORDANCE WITH § 15-1402 OF THIS SUBTITLE.

(D) THE COMMISSIONER SHALL:

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

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

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

(E) IF THE COMMISSIONER DETERMINES THAT AN ADVERSE DECISION IS IMPROPER, THE COMMISSIONER MAY ORDER THE CARRIER TO PAY FOR THE HEALTH CARE SERVICE.

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

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15-1405.

ON A QUARTERLY BASIS, EACH CARRIER SHALL SUBMIT TO THE COMMISSIONER, ON A FORM REQUIRED BY THE COMMISSIONER, A REPORT THAT DESCRIBES:

(1) ACTIVITIES OF THE CARRIER UNDER THIS SUBTITLE, INCLUDING:

(I) THE OUTCOME OF EACH GRIEVANCE ABOUT WHICH A MEMBER CONTACTED THE CARRIER;

(II) THE NUMBER AND RESULTS OF CASES THAT ARE CONSIDERED EMERGENCY CASES AND URGENT CASES UNDER § 15-1403(B)(2)(I) OR (II) OF THIS SUBTITLE;

(III) THE TIME WITHIN WHICH THE CARRIER COMPLETED ITS GRIEVANCE PROCESS FOR EACH EMERGENCY CASE AND URGENT CASE;

(IV) THE TIME WITHIN WHICH THE CARRIER COMPLETED ITS GRIEVANCE PROCESS IN ALL OTHER CASES; AND

(V) THE NUMBER OF CASES RELATING TO LENGTH OF STAY FOR INPATIENT HOSPITALIZATION AND THE PROCEDURES INVOLVED; AND

(2) THE NUMBER AND OUTCOME OF ALL OTHER CASES THAT RELATE TO LENGTH OF STAY FOR INPATIENT HOSPITALIZATION AND THE PROCEDURES INVOLVED THAT ARE NOT SUBJECT TO ACTIVITIES OF THE CARRIER UNDER THIS SUBTITLE.

~~15-1404.~~ 15-1406.

(A) 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.

(B) 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.

(C) 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~~ PROCEDURES AVAILABLE TO MEMBERS UNDER THIS SUBTITLE AND PROPOSE CHANGES DEEMED NECESSARY.

(D) ON A QUARTERLY BASIS, THE HEALTH ADVOCACY UNIT SHALL SUBMIT A REPORT TO THE MARYLAND INSURANCE ADMINISTRATION THAT:

(1) DESCRIBES ACTIVITIES OF THE UNIT ON BEHALF OF 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 INSTANCE DESCRIBED IN THE REPORT; AND

(4) STATES THE RESULT IN EACH INSTANCE DESCRIBED IN THE REPORT.

27-303.

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

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

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

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

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

(5) 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;

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

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

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

(8) REFUSE TO PAY A CLAIM WITHOUT CONDUCTING A REASONABLE INVESTIGATION BASED ON ALL AVAILABLE INFORMATION.

~~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;~~

~~(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) FAIL TO REIMBURSE FOR MEDICALLY NECESSARY COVERED BENEFITS.~~

Article - Commercial Law

13-4A-04.

THE UNIT SHALL PREPARE EACH ANNUAL AND QUARTERLY REPORT REQUIRED IN ACCORDANCE WITH § 15-1406 OF THE INSURANCE ARTICLE.

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 the format and contents of the annual report required under § ~~15-1404~~ 15-1406 of the Insurance Article, as enacted by Section 1 of this Act.

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 on or before December 31 of each year, the Insurance Commissioner shall submit a report to the House Economic Matters Committee and the Senate Finance Committee that is based on the information submitted by carriers under § 15-1405(1) and (2) of the Insurance Article.

SECTION 5. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect June 1, 1997.

SECTION ~~5.~~ 6. AND BE IT FURTHER ENACTED, That, except as provided in Section ~~4.~~ 5 of this Act, this Act shall take effect October 1, 1997.