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By: Senators Astle, Della, Derr, Teitelbaum, Ruben, Trotter, Hollinger, Hughes, Dorman, and Hafer
Introduced and read first time: January 31, 1997
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance - Health Care Benefits Complaint and Appeal Process

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 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; 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, inclusive, to be under the new subtitle "Subtitle 14. Health Care Benefits Complaint and Appeal Process"
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)

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.

15-1401.

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

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

(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) "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) "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.

(2) "MEMBER" INCLUDES A SUBSCRIBER.

15-1402.

(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;

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

(4) QUALIFICATIONS OF PERSONS MAKING ADVERSE DECISIONS.

(B) EACH CARRIER SHALL:

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

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

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

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

(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.

(2) THE NOTICE OF AN ADVERSE DECISION SHALL:

(I) STATE 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 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.

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

(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 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 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) 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.

(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.

(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.

(E) 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.

15-1404.

(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 AND PROPOSE CHANGES DEEMED NECESSARY.

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.

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.

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 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 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, except as provided in Section 4 of this Act, this Act shall take effect October 1, 1997.