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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

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 26, 1997

CHAPTER ____

AN ACT concerning

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

FOR the purpose of requiring a carrier to establish a certain internal ~~complaint and review~~ grievance process for members; requiring a carrier to file a copy of its internal ~~complaint and review~~ grievance 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~~ certain information when the member contacts the carrier concerning an adverse decision; 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~~ 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; 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 order payment under certain circumstances; requiring the Commissioner to advise certain parties of the opportunity for requesting a certain hearing; authorizing the Commissioner to refer other complaints ~~and appeals to the~~

~~Health Education and Advocacy Unit or~~ to an appropriate government agency; requiring the Health Education and Advocacy Unit to prepare and publish ~~a certain report~~ certain reports and provide copies of ~~the~~ a certain report to certain committees of the General Assembly; 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; 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; requiring a certain Maryland Insurance Administration annual report to provide certain information; providing for the effect of certain provisions of this Act; defining certain terms; providing for the effective dates of this Act; providing for the termination of certain provisions 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~~ 15-1405, inclusive, to be under the new subtitle "Subtitle 14. ~~Health Care Benefits Complaint and Appeal Process~~ Complaint Process for Adverse Decisions or Grievances"
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~~ ADVERSE DECISIONS OR GRIEVANCE DECISIONS.

SUBTITLE 14. ~~HEALTH CARE BENEFITS COMPLAINT AND APPEAL PROCESS~~ COMPLAINT PROCESS FOR ADVERSE DECISIONS OR GRIEVANCES.

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~~ 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 ~~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) "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.

~~(E)~~ (G) "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.~~

(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 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.~~

(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.

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

(1) FILE WITH THE COMMISSIONER AND 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:~~

(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;

~~(1)~~ (2) THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO ASSIST THE MEMBER WITH FILING ~~THE COMPLAINT~~ A GRIEVANCE UNDER THE CARRIER'S INTERNAL ~~COMPLAINT AND REVIEW~~ 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~~ OFFERS A MEDIATION SERVICE THAT MAY ASSIST THE MEMBER;

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

(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

~~(4)~~ (7) WHERE THE INFORMATION REQUIRED BY THIS SUBSECTION CAN BE FOUND IN THE MEMBER'S POLICY, CERTIFICATE, ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE.

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

(2) THE NOTICE OF ~~AN ADVERSE~~ 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 ~~IS~~ AND GRIEVANCE DECISION ARE BASED; AND

(III) PROVIDE THE FOLLOWING INFORMATION:

1. THE RIGHT OF THE MEMBER TO FILE ~~AN APPEAL~~ 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.

~~(E)~~ (H) EACH CARRIER SHALL INCLUDE THE INFORMATION REQUIRED BY SUBSECTIONS ~~(C)~~ (F) AND ~~(D)~~ (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)~~ (I) THIS SECTION DOES NOT LIMIT THE RIGHT OF ANY MEMBER TO:

(1) FILE A COMPLAINT:

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

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

(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) (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) 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 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.

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

~~(3)~~ (4) 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 PARAGRAPH (2) OF THIS SUBSECTION.

~~(E)~~ (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.

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.

~~(A)~~ (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.

~~(B)~~ (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.

~~(C)~~ (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.

~~27-303.~~

~~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) IMPROPERLY 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 provisions enacted by Section 1 of this Act regarding: (1) the format and contents of the annual report required under § 15-1404 of the Insurance Article~~, as enacted by Section 1 of this Act~~; 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 the affected agencies, 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.

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 ~~5.~~ 7. AND BE IT FURTHER ENACTED, That, except as provided in Section 4 of this Act, this Act shall take effect ~~October 1, 1997~~ January 1, 1998.