HOUSE BILL 405

Unofficial Copy 2000 Regular Session
C3 (0lr0174)

ENROLLED BILL
-- Economic Matters/Finance --

Introduced by **Chairman, Economic Matters Committee (Departmental - Insurance Administration, Maryland)**

Read and Examined by Proofreaders:

_____
Proofreader.

_____
Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this _____ day of _____ at _____ o'clock, _____M.

_____
Speaker.

CHAPTER_____

AN ACT concerning

Health Insurance - Internal Appeal and Grievance Processes

FOR the purpose of requiring certain carriers to document an adverse decision and to include certain information in a written notice of an adverse decision to certain persons; requiring certain carriers to include certain information in a notice of a grievance decision to certain persons; requiring carriers to establish an internal appeal process for use by their members and health care providers for disputes relating to coverage decisions and providing that carriers can comply with this requirement in a certain manner; requiring carriers to provide certain information concerning the internal appeal process to members under certain circumstances; requiring carriers to send members and certain health care providers written notice of ~~a~~ coverage ~~decision~~ decisions and appeal decisions within certain time limits under certain circumstances; requiring certain carriers to include certain information in a notice of ~~a~~ coverage ~~decision;~~ decisions and appeal decisions; authorizing the Insurance Commissioner to request authorization to release certain records under certain circumstances;

requiring carriers to meet the burden of persuasion in certain circumstances; authorizing the Commissioner to consider certain information in reviewing a complaint; requiring the Commissioner to make and issue a final decision on a complaint under certain circumstances; requiring the Commissioner to include certain information in a certain notice to certain persons; providing that a certain failure of a carrier is a certain violation; authorizing the Commissioner to take certain ~~action~~ actions against a carrier for certain violations; authorizing the Commissioner to adopt certain regulations; making stylistic and technical changes; defining certain terms; providing for a delayed effective date for certain provisions of this Act; and generally relating to a carrier's internal appeal and grievance processes.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-10A-02(f), (i), (j), and (k)
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

BY adding to
Article - Insurance
Section 15-10D-01 through ~~15-10D-05~~ 15-10D-04, inclusive, to be under the new subtitle "Subtitle 10D. Complaint Process for Coverage Decisions"
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

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

Article - Insurance

15-10A-02.

(f) [Except for an emergency case under subsection (b)(2)(i) of this section, at the time a member first contacts a carrier about an adverse decision, the carrier shall send in writing to the member within 2 working days after the initial contact:

(1) the details of its internal grievance process and procedures under the provisions of this subtitle;

(2) information stating that:

(i) the Health Advocacy Unit:

1. is available to assist the member with filing a grievance under the carrier's internal grievance process; but

2. is not available to represent or accompany the member during the proceedings of the internal grievance process;

(ii) the Health Advocacy Unit can assist the member in mediating a resolution of the adverse decision with the carrier, but that any time during the mediation, the member or a health care provider on behalf of the member may file a grievance; and

(iii) the member or a health care provider on behalf of the member may file a complaint with the Commissioner without first filing a grievance if sufficient information and supporting documentation is filed with the complaint that demonstrates a compelling reason to do so;

(3) the address, telephone number, facsimile number, and e-mail address of the Health Advocacy Unit;

(4) the address, telephone number, and facsimile number of the Commissioner; and

(5) information on where the information required by this subsection can be found in the member's policy, plan, certificate, enrollment materials, or other evidence of coverage.]

FOR NONEMERGENCY CASES, WHEN A CARRIER RENDERS AN ADVERSE DECISION, THE CARRIER SHALL:

(1) DOCUMENT THE ADVERSE DECISION IN WRITING AFTER THE CARRIER HAS PROVIDED ORAL COMMUNICATION OF THE DECISION TO THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER; AND

(2) SEND, WITHIN 5 WORKING DAYS AFTER THE ADVERSE DECISION HAS BEEN MADE, A WRITTEN NOTICE TO THE MEMBER AND A HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER THAT:

~~(1)~~ (I) STATES IN DETAIL IN CLEAR, UNDERSTANDABLE LANGUAGE THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION;

~~(2)~~ (II) REFERENCES THE SPECIFIC CRITERIA AND STANDARDS, INCLUDING INTERPRETIVE GUIDELINES, ON WHICH THE DECISION WAS BASED, AND MAY NOT SOLELY USE GENERALIZED TERMS SUCH AS "EXPERIMENTAL PROCEDURE NOT COVERED", "COSMETIC PROCEDURE NOT COVERED", "SERVICE INCLUDED UNDER ANOTHER PROCEDURE", OR "NOT MEDICALLY NECESSARY";

~~(3)~~ (III) STATES THE NAME, BUSINESS ADDRESS, AND BUSINESS TELEPHONE NUMBER OF:

~~(I)~~ 1. THE MEDICAL DIRECTOR OR ASSOCIATE MEDICAL DIRECTOR, AS APPROPRIATE, WHO MADE THE DECISION IF THE CARRIER IS A HEALTH MAINTENANCE ORGANIZATION; OR

~~(II)~~ 2. THE DESIGNATED EMPLOYEE OR REPRESENTATIVE OF THE CARRIER WHO HAS RESPONSIBILITY FOR THE CARRIER'S INTERNAL GRIEVANCE PROCESS IF THE CARRIER IS NOT A HEALTH MAINTENANCE ORGANIZATION;

~~(4)~~ (IV) GIVES WRITTEN DETAILS OF THE CARRIER'S INTERNAL GRIEVANCE PROCESS AND PROCEDURES UNDER THIS SUBTITLE; AND

~~(5)~~ (V) INCLUDES THE FOLLOWING INFORMATION:

~~(I)~~ 1. THAT THE MEMBER OR A PROVIDER ON BEHALF OF THE MEMBER HAS A RIGHT TO FILE A COMPLAINT WITH THE COMMISSIONER WITHIN 30 DAYS AFTER RECEIPT OF A CARRIER'S GRIEVANCE DECISION;

~~(II)~~ 2. THAT A COMPLAINT MAY BE FILED WITHOUT FIRST FILING A GRIEVANCE IF THE MEMBER OR A HEALTH CARE PROVIDER FILING A GRIEVANCE ON BEHALF OF THE MEMBER CAN DEMONSTRATE A COMPELLING REASON TO DO SO AS DETERMINED BY THE COMMISSIONER; ~~AND~~

~~(III)~~ 3. THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER, AND FACSIMILE NUMBER; ~~AND~~

4. A STATEMENT THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO ASSIST THE MEMBER IN BOTH MEDIATING AND FILING A GRIEVANCE UNDER THE CARRIER'S INTERNAL GRIEVANCE PROCESS; AND

5. THE ADDRESS, TELEPHONE NUMBER, FACSIMILE NUMBER, AND EMAIL ADDRESS OF THE HEALTH ADVOCACY UNIT.

~~(6) INCLUDES THE FOLLOWING DISCLOSURE IN AT LEAST 12 POINT TYPEFACE, WITH THE FIRST SENTENCE IN BOLD CAPITAL TYPEFACE:~~

~~"THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. YOU MAY CONTACT THE HEALTH ADVOCACY UNIT OF MARYLAND'S CONSUMER PROTECTION DIVISION AT (PHONE NUMBER, ADDRESS, FAX, E-MAIL).~~

~~THE HEALTH ADVOCACY UNIT CAN HELP YOU AND YOUR HEALTH CARE PROVIDER PREPARE A GRIEVANCE TO FILE UNDER THE CARRIER'S INTERNAL GRIEVANCE PROCEDURE. THAT UNIT CAN ALSO ATTEMPT TO MEDIATE A RESOLUTION TO YOUR DISPUTE. THE HEALTH ADVOCACY UNIT IS NOT AVAILABLE TO REPRESENT OR ACCOMPANY YOU DURING ANY PROCEEDING OF THE INTERNAL GRIEVANCE PROCESS.~~

~~ADDITIONALLY, YOU MAY FILE A COMPLAINT WITH THE MARYLAND INSURANCE ADMINISTRATION, WITHOUT HAVING TO FIRST FILE A GRIEVANCE WITH THE PLAN, IF:~~

~~(1) THE PLAN HAS DENIED AUTHORIZATION FOR A HEALTH CARE SERVICE NOT YET PROVIDED TO YOU; AND~~

~~(2) YOU OR YOUR PROVIDER CAN SHOW A COMPELLING REASON TO FILE A COMPLAINT, INCLUDING THAT A DELAY IN RECEIVING THE HEALTH CARE SERVICE COULD RESULT IN LOSS OF LIFE, SERIOUS IMPAIRMENT TO A BODILY FUNCTION, OR SERIOUS DYSFUNCTION OF A BODILY ORGAN OR PART, OR THE MEMBER REMAINING~~

~~SERIOUSLY MENTALLY ILL WITH SYMPTOMS THAT CAUSE THE MEMBER TO BE A DANGER TO SELF OR OTHERS. INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN (CITE POLICY, PLAN, CERTIFICATE, ENROLLMENT MATERIALS, OR OTHER EVIDENCE OF COVERAGE)."~~

(i) [(1) For nonemergency cases, each carrier's internal grievance process established under subsection (a) of this section shall include a provision that requires the carrier to:

(i) document in writing any adverse decision or grievance decision made by the carrier after the carrier has provided oral communication of the decision to the member or the health care provider who filed the grievance on behalf of the member; and

(ii) within 5 working days after the decision has been made, send notice of the adverse decision or grievance decision to:

1. the member; and

2. if the grievance was filed on behalf of the member under subsection (b)(2)(iii) of this section, the health care provider.

(2) Notice of the adverse decision or grievance decision required to be sent under paragraph (1) of this subsection shall:]

(1) FOR NONEMERGENCY CASES, WHEN A CARRIER RENDERS A GRIEVANCE DECISION, THE CARRIER SHALL:

(I) DOCUMENT THE GRIEVANCE DECISION IN WRITING AFTER THE CARRIER HAS PROVIDED ORAL COMMUNICATION OF THE DECISION TO THE MEMBER OR THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER; AND

(II) SEND, WITHIN 5 WORKING DAYS AFTER THE GRIEVANCE DECISION HAS BEEN MADE, A WRITTEN NOTICE TO THE MEMBER AND A HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER THAT:

~~(i)~~ 1. [state] STATES in detail in clear, understandable language the specific factual bases for the carrier's decision;

~~(ii)~~ 2. [reference] REFERENCES the specific criteria and standards, including interpretive guidelines, on which the [adverse decision or] grievance decision was based;

~~(iii)~~ 3. [state] STATES the name, business address, and business telephone number of:

~~1.~~ A. the medical director or associate medical director, as appropriate, who made the [adverse decision or] grievance decision if the carrier is a health maintenance organization; or

~~2.~~ B. the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization; and

~~(iv)~~ 4. [include] INCLUDES the following information:

~~1.~~ A. that the member has a right to file a complaint with the Commissioner within 30 days after receipt of a carrier's grievance decision; AND

~~2. that a complaint may be filed without first filing a grievance if the member or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so; and~~

~~3.~~ B. the Commissioner's address, telephone number, and facsimile number.

[(3)] (2) A carrier may not use solely in a notice sent under paragraph (1) of this subsection generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary" to satisfy the requirements of [paragraph (2)(i) or (ii) of] this subsection.

(j) (1) For an emergency case under subsection (b)(2)(i) of this section, within 1 day after a decision has been orally communicated to the member or health care provider, the carrier shall send notice in writing of any adverse decision or grievance decision to:

(i) the member; and

(ii) if the grievance was filed on behalf of the member under subsection (b)(2)(iii) of this section, the health care provider.

(2) [The] A notice REQUIRED TO BE SENT UNDER PARAGRAPH (1) OF THIS SUBSECTION shall include the [information required under subsection (i)(2) of this section] FOLLOWING:

(I) FOR AN ADVERSE DECISION, THE INFORMATION REQUIRED UNDER SUBSECTION (F) OF THIS SECTION; AND

(II) FOR A GRIEVANCE DECISION, THE INFORMATION REQUIRED UNDER SUBSECTION (I) OF THIS SECTION.

(k) Each carrier shall include the information required by ~~subsections (f) and [(i)(2)(iii)] (I)~~ SUBSECTION (F)(2)(III), (IV), AND (V) of this section in the policy, plan, certificate, enrollment materials, or other evidence of coverage that the carrier provides to a member at the time of the member's initial coverage or renewal of coverage.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

SUBTITLE 10D. COMPLAINT PROCESS FOR COVERAGE DECISIONS.

15-10D-01.

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

(B) "APPEAL" MEANS A PROTEST FILED BY A MEMBER OR A HEALTH CARE PROVIDER WITH A CARRIER UNDER ITS INTERNAL APPEAL PROCESS REGARDING A COVERAGE DECISION CONCERNING A MEMBER.

(C) "APPEAL DECISION" MEANS A FINAL DETERMINATION BY A CARRIER THAT ARISES FROM AN APPEAL FILED WITH THE CARRIER UNDER ITS APPEAL PROCESS REGARDING A COVERAGE DECISION CONCERNING A MEMBER.

(D) "CARRIER" MEANS A PERSON THAT OFFERS A HEALTH ~~CARE SERVICES~~ BENEFIT PLAN AND IS:

(1) AN AUTHORIZED INSURER THAT PROVIDES HEALTH INSURANCE IN THE STATE;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION;

(4) A DENTAL PLAN ORGANIZATION; OR

(5) EXCEPT FOR A MANAGED CARE ORGANIZATION, AS DEFINED IN TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE, ANY OTHER PERSON THAT ~~PROVIDES~~ OFFERS A HEALTH ~~CARE SERVICES~~ BENEFIT PLAN SUBJECT TO REGULATION BY THE STATE.

(E) "COMPLAINT" MEANS A PROTEST FILED WITH THE COMMISSIONER INVOLVING A COVERAGE DECISION ~~NOT TO PAY A CLAIM FOR HEALTH CARE SERVICES~~ OTHER THAN THAT WHICH IS COVERED BY SUBTITLE 10A OF THIS TITLE.

(F) (1) "COVERAGE DECISION" MEANS ~~A FINAL~~ AN INITIAL DETERMINATION BY A CARRIER OR A REPRESENTATIVE OF THE CARRIER THAT RESULTS IN NONCOVERAGE OF A HEALTH CARE SERVICE.

(2) "COVERAGE DECISION" INCLUDES ~~PAYMENT~~ NONPAYMENT OF ALL OR ANY PART OF A CLAIM.

(3) "COVERAGE DECISION" DOES NOT INCLUDE AN ADVERSE DECISION AS DEFINED IN § 15-10A-01(B) OF THIS TITLE.

(G) (1) "HEALTH BENEFIT PLAN" MEANS:

(I) A HOSPITAL OR MEDICAL POLICY OR CONTRACT, INCLUDING A POLICY OR CONTRACT ISSUED UNDER A MULTIPLE EMPLOYER TRUST OR ASSOCIATION;

(II) A HOSPITAL OR MEDICAL POLICY OR CONTRACT ISSUED BY A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION CONTRACT; OR

(IV) A DENTAL PLAN ORGANIZATION CONTRACT.

(2) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE ONE OR MORE, OR ANY COMBINATION OF THE FOLLOWING:

(I) LONG-TERM CARE INSURANCE;

(II) DISABILITY INSURANCE;

(III) ACCIDENTAL TRAVEL AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE;

(IV) CREDIT HEALTH INSURANCE; ~~OR~~

(V) A HEALTH BENEFIT PLAN ISSUED BY A MANAGED CARE ORGANIZATION, AS DEFINED IN TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE*;*

(VI) DISEASE-SPECIFIC INSURANCE; OR

(VII) FIXED INDEMNITY INSURANCE.

~~(G)~~ (H) "HEALTH CARE PROVIDER" MEANS:

(1) AN INDIVIDUAL WHO IS LICENSED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION AND IS A TREATING PROVIDER OF THE MEMBER; OR

(2) A HOSPITAL, AS DEFINED IN § 19-301 OF THE HEALTH - GENERAL ARTICLE.

~~(H)~~ (I) "HEALTH CARE SERVICE" MEANS A HEALTH OR MEDICAL CARE PROCEDURE OR SERVICE RENDERED BY A HEALTH CARE PROVIDER THAT:

(1) PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION; OR

(2) DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION.

~~(I)~~ (J) (1) "MEMBER" MEANS A PERSON ENTITLED TO HEALTH CARE ~~BENEFITS~~ SERVICES UNDER A POLICY, PLAN, OR ~~CERTIFICATE~~ CONTRACT ISSUED OR DELIVERED IN THE STATE BY A CARRIER.

(2) "MEMBER" INCLUDES:

(I) A SUBSCRIBER; AND

(II) UNLESS PREEMPTED BY FEDERAL LAW, A MEDICARE RECIPIENT.

(3) "MEMBER" DOES NOT INCLUDE A MEDICAID RECIPIENT.

15-10D-02.

~~THIS SUBTITLE APPLIES TO A CARRIER FOR ANY CONTRACT THAT:~~

~~(1) IS DELIVERED OR ISSUED IN THE STATE; OR~~

~~(2) COVERS INDIVIDUALS WHO RESIDE OR WORK IN THE STATE IF THE CONTRACT IS DELIVERED OR ISSUED IN A STATE THAT THE COMMISSIONER DETERMINES DOES NOT HAVE AN EXTERNAL COMPLAINT PROCESS FOR APPEALS COMPARABLE TO THE COMPLAINT PROCESS ESTABLISHED IN THIS SUBTITLE.~~

~~15-10D-03.~~

(A) (1) ~~IN ADDITION TO THE REQUIREMENTS OF SUBTITLE 10A OF THIS TITLE,~~ EACH CARRIER SHALL ESTABLISH AN INTERNAL APPEAL PROCESS FOR USE BY ITS MEMBERS AND HEALTH CARE PROVIDERS TO DISPUTE COVERAGE DECISIONS MADE BY THE CARRIER.

(2) THE CARRIER MAY USE THE INTERNAL GRIEVANCE PROCESS ESTABLISHED UNDER SUBTITLE 10A OF THIS TITLE TO COMPLY WITH THE REQUIREMENT OF PARAGRAPH (1) OF THIS SUBSECTION.

~~(B) (1) AN INTERNAL APPEAL PROCESS SHALL INCLUDE AN EXPEDITED PROCEDURE FOR USE IN AN EMERGENCY CASE FOR PURPOSES OF RENDERING AN APPEAL DECISION WITHIN 24 HOURS AFTER THE DATE AN APPEAL IS FILED WITH THE CARRIER.~~

~~(2) THE INTERNAL APPEAL PROCESS SHALL PROVIDE THAT A CARRIER RENDER AN APPEAL DECISION IN WRITING.~~

(B) AN INTERNAL APPEAL PROCESS ESTABLISHED BY A CARRIER UNDER THIS SECTION SHALL PROVIDE THAT A CARRIER RENDER A FINAL DECISION IN WRITING TO A MEMBER, AND A HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER, WITHIN 60 WORKING DAYS AFTER THE DATE ON WHICH THE APPEAL IS FILED.

(C) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, THE CARRIER'S INTERNAL APPEAL PROCESS SHALL BE EXHAUSTED PRIOR TO FILING A COMPLAINT WITH THE COMMISSIONER UNDER THIS SUBTITLE.

(D) ~~(1)~~ A MEMBER OR A HEALTH CARE PROVIDER FILING A COMPLAINT ON BEHALF OF A MEMBER MAY FILE A COMPLAINT WITH THE COMMISSIONER WITHOUT FIRST FILING AN APPEAL WITH A CARRIER ONLY IF THE COVERAGE DECISION INVOLVES AN URGENT MEDICAL CONDITION, *AS DEFINED BY REGULATION ADOPTED*

BY THE COMMISSIONER, FOR WHICH CARE HAS NOT BEEN RENDERED ~~AND RECEIVING AN APPEAL DECISION IF THE MEMBER OR THE HEALTH CARE PROVIDER PROVIDES SUFFICIENT INFORMATION AND SUPPORTING DOCUMENTATION IN THE COMPLAINT THAT DEMONSTRATES A COMPELLING REASON TO DO SO~~.

~~(2) THE COMMISSIONER SHALL DEFINE BY REGULATION THE STANDARDS THAT THE COMMISSIONER SHALL USE TO DECIDE WHAT DEMONSTRATES A COMPELLING REASON UNDER PARAGRAPH (1) OF THIS SUBSECTION.~~

~~(E) (1) FOR NONEMERGENCY CASES, EACH CARRIER'S INTERNAL APPEAL PROCESS ESTABLISHED UNDER SUBSECTION (A) OF THIS SECTION SHALL INCLUDE A PROVISION THAT REQUIRES THE CARRIER TO:~~

~~(I) DOCUMENT IN WRITING ANY COVERAGE DECISION OR APPEAL DECISION MADE BY THE CARRIER; AND~~

~~(II) WITHIN 5 WORKING DAYS AFTER THE DECISION HAS BEEN MADE, SEND NOTICE OF THE COVERAGE DECISION OR APPEAL DECISION TO:~~

~~1. THE MEMBER; AND~~

~~2. IF THE GRIEVANCE WAS FILED ON BEHALF OF THE MEMBER, THE HEALTH CARE PROVIDER.~~

~~(2) NOTICE OF THE COVERAGE DECISION OR APPEAL DECISION REQUIRED TO BE SENT UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:~~

~~(I) STATE IN DETAIL IN CLEAR, UNDERSTANDABLE LANGUAGE THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION;~~

~~(II) INCLUDE THE FOLLOWING INFORMATION:~~

~~1. THAT THE MEMBER HAS A RIGHT TO FILE A COMPLAINT WITH THE COMMISSIONER WITHIN 30 DAYS AFTER RECEIPT OF A CARRIER'S APPEAL DECISION;~~

~~2. THAT A COMPLAINT MAY BE FILED WITHOUT FIRST FILING AN APPEAL IF THE MEMBER OR A HEALTH CARE PROVIDER FILING AN APPEAL ON BEHALF OF THE MEMBER CAN DEMONSTRATE A COMPELLING REASON TO DO SO; AND~~

~~3. THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER, AND FACSIMILE NUMBER.~~

(E) (1) WITHIN 30 CALENDAR DAYS AFTER A COVERAGE DECISION HAS BEEN MADE, A CARRIER SHALL SEND A WRITTEN NOTICE OF THE COVERAGE DECISION TO THE MEMBER AND, IN THE CASE OF A HEALTH MAINTENANCE ORGANIZATION, THE TREATING HEALTH CARE PROVIDER.

(2) NOTICE OF THE COVERAGE DECISION REQUIRED TO BE SENT UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

(I) STATE IN DETAIL IN CLEAR, UNDERSTANDABLE LANGUAGE, THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION; AND

(II) INCLUDE THE FOLLOWING INFORMATION:

1. THAT THE MEMBER, OR A HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER, HAS A RIGHT TO FILE AN APPEAL WITH THE CARRIER;

2. THAT THE MEMBER, OR A HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER, MAY FILE A COMPLAINT WITH THE COMMISSIONER WITHOUT FIRST FILING AN APPEAL, IF THE COVERAGE DECISION INVOLVES AN URGENT MEDICAL CONDITION FOR WHICH CARE HAS NOT BEEN RENDERED; ~~AND~~

3. THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER, AND FACSIMILE NUMBER;

4. THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO ASSIST THE MEMBER IN BOTH MEDIATING AND FILING AN APPEAL UNDER THE CARRIER'S INTERNAL APPEAL PROCESS; AND

5. THE ADDRESS, TELEPHONE NUMBER, FACSIMILE NUMBER, AND EMAIL ADDRESS OF THE HEALTH ADVOCACY UNIT.

(F) (1) WITHIN 30 CALENDAR DAYS AFTER THE APPEAL DECISION HAS BEEN MADE, EACH CARRIER SHALL SEND TO THE MEMBER, AND THE HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER, A WRITTEN NOTICE OF THE APPEAL DECISION.

(2) NOTICE OF THE APPEAL DECISION REQUIRED TO BE SENT UNDER PARAGRAPH (1) OF THE SUBSECTION SHALL:

(I) STATE IN DETAIL IN CLEAR, UNDERSTANDABLE LANGUAGE THE SPECIFIC FACTUAL BASES FOR THE CARRIER'S DECISION; AND

(II) INCLUDE THE FOLLOWING INFORMATION:

1. THAT THE MEMBER, OR A HEALTH CARE PROVIDER ACTING ON BEHALF OF THE MEMBER, HAS A RIGHT TO FILE A COMPLAINT WITH THE COMMISSIONER WITHIN 60 WORKING DAYS AFTER RECEIPT OF A CARRIER'S APPEAL DECISION; AND

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

~~(F)~~ (G) THE COMMISSIONER MAY REQUEST THE MEMBER THAT FILED THE COMPLAINT OR A LEGALLY AUTHORIZED DESIGNEE OF THE MEMBER TO SIGN A CONSENT FORM AUTHORIZING THE RELEASE OF THE MEMBER'S MEDICAL RECORDS TO THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE THAT ARE NEEDED IN ORDER FOR THE COMMISSIONER TO MAKE A FINAL DECISION ON THE COMPLAINT.

~~(G)~~ (H) (1) DURING THE REVIEW OF A COMPLAINT BY THE COMMISSIONER OR A DESIGNEE OF THE COMMISSIONER, A CARRIER SHALL HAVE THE BURDEN OF PERSUASION THAT ITS COVERAGE DECISION OR APPEAL DECISION, AS APPLICABLE, IS CORRECT.

(2) AS PART OF THE REVIEW OF A COMPLAINT, THE COMMISSIONER OR A DESIGNEE OF THE COMMISSIONER MAY CONSIDER ALL OF THE FACTS OF THE CASE AND ANY OTHER EVIDENCE THAT THE COMMISSIONER OR DESIGNEE OF THE COMMISSIONER CONSIDERS APPROPRIATE.

~~(H)~~ (I) THE COMMISSIONER SHALL:

(1) MAKE AND ISSUE IN WRITING A FINAL DECISION ON ALL COMPLAINTS FILED WITH THE COMMISSIONER UNDER THIS SUBTITLE THAT ARE WITHIN THE COMMISSIONER'S JURISDICTION; AND

(2) PROVIDE NOTICE IN WRITING TO ALL PARTIES TO A COMPLAINT OF 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 A FINAL DECISION OF THE COMMISSIONER MADE AND ISSUED UNDER THIS SUBTITLE.

~~15-10D-04.~~ 15-10D-03.

(A) IT IS A VIOLATION OF THIS SUBTITLE FOR A CARRIER TO FAIL TO FULFILL THE CARRIER'S OBLIGATIONS TO PROVIDE OR REIMBURSE FOR HEALTH CARE SERVICES SPECIFIED IN THE CARRIER'S POLICIES OR CONTRACTS WITH MEMBERS.

(B) IF, IN RENDERING A COVERAGE DECISION OR APPEAL DECISION, A CARRIER FAILS TO FULFILL THE CARRIER'S POLICIES OR CONTRACTS WITH MEMBERS, THE COMMISSIONER MAY:

(1) ISSUE AN ADMINISTRATIVE ORDER THAT REQUIRES THE CARRIER TO:

(I) CEASE INAPPROPRIATE CONDUCT OR PRACTICES BY THE CARRIER OR ANY OF THE PERSONNEL EMPLOYED OR ASSOCIATED WITH THE CARRIER;

(II) FULFILL THE CARRIER'S CONTRACTUAL OBLIGATIONS;

(III) PROVIDE A HEALTH CARE SERVICE OR PAYMENT THAT HAS BEEN DENIED IMPROPERLY; OR

(IV) TAKE APPROPRIATE STEPS TO RESTORE THE CARRIER'S ABILITY TO PROVIDE A HEALTH CARE SERVICE OR PAYMENT THAT IS PROVIDED UNDER A CONTRACT; OR

(2) IMPOSE ANY PENALTY OR FINE OR TAKE ANY ACTION AS AUTHORIZED:

(I) FOR AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR DENTAL PLAN ORGANIZATION, UNDER THIS ARTICLE; OR

(II) FOR A HEALTH MAINTENANCE ORGANIZATION, UNDER THE HEALTH - GENERAL ARTICLE OR UNDER THIS ARTICLE.

~~15-10D-05.~~ 15-10D-04.

THE COMMISSIONER MAY ADOPT ANY NECESSARY REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS SUBTITLE.

SECTION 3. AND BE IT FURTHER ENACTED, That, notwithstanding any policy or benefit statement to the contrary, Section 2 of this Act shall take effect January 1, 2001.

SECTION 4. AND BE IT FURTHER ENACTED, That, except as provided in Section 3 of this Act, this Act shall take effect ~~July 1, 2000~~ October 1, 2000.