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By: **Chairman, Economic Matters Committee (Departmental - Insurance Administration, Maryland)**

Introduced and read first time: February 3, 2000

Assigned to: Economic Matters

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Committee Report: Favorable with amendments

House action: Adopted with floor amendments

Read second time: March 7, 2000

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CHAPTER \_\_\_\_\_

1 AN ACT concerning

2 **Health Insurance - Internal Appeal and Grievance Processes**

3 FOR the purpose of requiring certain carriers to document an adverse decision and to  
4 include certain information in a written notice of an adverse decision to certain  
5 persons; requiring certain carriers to include certain information in a notice of a  
6 grievance decision to certain persons; requiring carriers to establish an internal  
7 appeal process for use by their members and health care providers for disputes  
8 relating to coverage decisions and providing that carriers can comply with this  
9 requirement in a certain manner; requiring carriers to provide certain  
10 information concerning the internal appeal process to members under certain  
11 circumstances; requiring carriers to send members and certain health care  
12 providers written notice of a coverage decision decisions and appeal decisions  
13 within certain time limits under certain circumstances; requiring certain  
14 carriers to include certain information in a notice of a coverage decision;  
15 decisions and appeal decisions; authorizing the Insurance Commissioner to  
16 request authorization to release certain records under certain circumstances;  
17 requiring carriers to meet the burden of persuasion in certain circumstances;  
18 authorizing the Commissioner to consider certain information in reviewing a  
19 complaint; requiring the Commissioner to make and issue a final decision on a  
20 complaint under certain circumstances; requiring the Commissioner to include  
21 certain information in a certain notice to certain persons; providing that a  
22 certain failure of a carrier is a certain violation; authorizing the Commissioner  
23 to take certain action actions against a carrier for certain violations; authorizing  
24 the Commissioner to adopt certain regulations; making stylistic and technical  
25 changes; defining certain terms; providing for a delayed effective date for  
26 certain provisions of this Act; and generally relating to a carrier's internal  
27 appeal and grievance processes.

1 BY repealing and reenacting, with amendments,  
 2 Article - Insurance  
 3 Section 15-10A-02(f), (i), (j), and (k)  
 4 Annotated Code of Maryland  
 5 (1997 Volume and 1999 Supplement)

6 BY adding to  
 7 Article - Insurance  
 8 Section 15-10D-01 through ~~15-10D-05~~ 15-10D-04, inclusive, to be under the  
 9 new subtitle "Subtitle 10D. Complaint Process for Coverage Decisions"  
 10 Annotated Code of Maryland  
 11 (1997 Volume and 1999 Supplement)

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

14 **Article - Insurance**

15 15-10A-02.

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

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

21 (2) information stating that:

22 (i) the Health Advocacy Unit:

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

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

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

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

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

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

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

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

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

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

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

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

23 (⊕) (III) STATES THE NAME, BUSINESS ADDRESS, AND BUSINESS  
24 TELEPHONE NUMBER OF:

25 (⊕) 1. THE MEDICAL DIRECTOR OR ASSOCIATE MEDICAL DIRECTOR,  
26 AS APPROPRIATE, WHO MADE THE DECISION IF THE CARRIER IS A HEALTH  
27 MAINTENANCE ORGANIZATION; OR

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

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

33 (⊕) (V) INCLUDES THE FOLLOWING INFORMATION:

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

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

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

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

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

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

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

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

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

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

29                   ~~(2)~~        ~~YOU OR YOUR PROVIDER CAN SHOW A COMPELLING REASON TO FILE~~  
30 ~~A COMPLAINT, INCLUDING THAT A DELAY IN RECEIVING THE HEALTH CARE SERVICE~~  
31 ~~COULD RESULT IN LOSS OF LIFE, SERIOUS IMPAIRMENT TO A BODILY FUNCTION, OR~~  
32 ~~SERIOUS DYSFUNCTION OF A BODILY ORGAN OR PART, OR THE MEMBER REMAINING~~  
33 ~~SERIOUSLY MENTALLY ILL WITH SYMPTOMS THAT CAUSE THE MEMBER TO BE A~~  
34 ~~DANGER TO SELF OR OTHERS. INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO~~  
35 ~~BE FOUND IN (CITE POLICY, PLAN, CERTIFICATE, ENROLLMENT MATERIALS, OR~~  
36 ~~OTHER EVIDENCE OF COVERAGE)."~~

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

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

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

7 1. the member; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 [(3)] (2) A carrier may not use solely in a notice sent under paragraph  
7 (1) of this subsection generalized terms such as "experimental procedure not covered",  
8 "cosmetic procedure not covered", "service included under another procedure", or "not  
9 medically necessary" to satisfy the requirements of [paragraph (2)(i) or (ii) of] this  
10 subsection.

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

15 (i) the member; and

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

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

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

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

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

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

32 SUBTITLE 10D. COMPLAINT PROCESS FOR COVERAGE DECISIONS.

33 15-10D-01.

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

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

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

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

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

11 (2) A NONPROFIT HEALTH SERVICE PLAN;

12 (3) A HEALTH MAINTENANCE ORGANIZATION;

13 (4) A DENTAL PLAN ORGANIZATION; OR

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

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

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

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

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

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

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

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

34 (III) A HEALTH MAINTENANCE ORGANIZATION CONTRACT; OR

35 (IV) A DENTAL PLAN ORGANIZATION CONTRACT.

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

3                   (I)     LONG-TERM CARE INSURANCE;

4                   (II)    DISABILITY INSURANCE;

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

7                   (IV)    CREDIT HEALTH INSURANCE; OR

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

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

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

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

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

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

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

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

27                   (2)     "MEMBER" INCLUDES:

28                   (I)     A SUBSCRIBER; AND

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

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



1 15-10D-02.

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

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

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

8 ~~15-10D-03.~~

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

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

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

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

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

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

29 (D) ~~(1) A MEMBER OR A HEALTH CARE PROVIDER FILING A COMPLAINT ON~~  
30 ~~BEHALF OF A MEMBER MAY FILE A COMPLAINT WITH THE COMMISSIONER WITHOUT~~  
31 ~~FIRST FILING AN APPEAL WITH A CARRIER ONLY IF THE COVERAGE DECISION~~  
32 ~~INVOLVES AN URGENT MEDICAL CONDITION FOR WHICH CARE HAS NOT BEEN~~  
33 ~~RENDERED AND RECEIVING AN APPEAL DECISION IF THE MEMBER OR THE HEALTH~~  
34 ~~CARE PROVIDER PROVIDES SUFFICIENT INFORMATION AND SUPPORTING~~  
35 ~~DOCUMENTATION IN THE COMPLAINT THAT DEMONSTRATES A COMPELLING~~  
36 ~~REASON TO DO SO.~~

37 ~~(2) THE COMMISSIONER SHALL DEFINE BY REGULATION THE~~  
38 ~~STANDARDS THAT THE COMMISSIONER SHALL USE TO DECIDE WHAT~~

1 DEMONSTRATES A COMPELLING REASON UNDER PARAGRAPH (1) OF THIS  
2 SUBSECTION.

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

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

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

10 1. THE MEMBER; AND

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

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

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

17 (II) INCLUDE THE FOLLOWING INFORMATION:

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

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

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

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

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

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

35 (II) INCLUDE THE FOLLOWING INFORMATION:

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

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

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

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

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

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

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

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

24                                   (II)        INCLUDE THE FOLLOWING INFORMATION:

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

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

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

36        ~~(G)~~    (H)        (1)        DURING THE REVIEW OF A COMPLAINT BY THE COMMISSIONER  
37 OR A DESIGNEE OF THE COMMISSIONER, A CARRIER SHALL HAVE THE BURDEN OF

1 PERSUASION THAT ITS COVERAGE DECISION OR APPEAL DECISION, AS APPLICABLE,  
2 IS CORRECT.

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

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

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

11 (2) PROVIDE NOTICE IN WRITING TO ALL PARTIES TO A COMPLAINT OF  
12 THE OPPORTUNITY AND TIME PERIOD FOR REQUESTING A HEARING TO BE HELD IN  
13 ACCORDANCE WITH TITLE 10 SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE TO  
14 CONTEST A FINAL DECISION OF THE COMMISSIONER MADE AND ISSUED UNDER THIS  
15 SUBTITLE.

16 ~~15-10D-04.~~ 15-10D-03.

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

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

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

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

28 (II) FULFILL THE CARRIER'S CONTRACTUAL OBLIGATIONS;

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

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

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

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

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

5 ~~15-10D-05.~~ 15-10D-04.

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

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

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