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By: **Delegates McHale, Hammen, Guns, and Donoghue**
Introduced and read first time: February 7, 2000
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

Health Insurance - Carriers - Records of Claims

FOR the purpose of requiring certain insurance carriers to maintain a certain record of claims submitted to the carriers; requiring the carriers to submit certain reports to the Maryland Insurance Commissioner at certain times; specifying the contents of the reports; authorizing the Commissioner to take certain actions after reviewing the reports; authorizing the Commissioner to find that a carrier has committed an unfair claim settlement practice and to impose certain penalties based on the information contained in the reports; requiring certain financial examinations and market conduct studies to include an examination of a carrier's compliance with this Act; defining a certain term; and generally relating to records of claims submitted to insurance carriers.

BY adding to
Article - Insurance
Section 15-1009
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

BY repealing and reenacting, without amendments,
Article - Insurance
Section 27-304 and 27-305
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

15-1009.

(A) IN THIS SECTION, "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.

(B) (1) EACH CARRIER SHALL MAINTAIN A RECORD OF THE NUMBER OF CLAIMS, BY CATEGORY:

(I) THAT ARE PAID WITHIN 30 DAYS AFTER THEIR INITIAL SUBMISSION;

(II) THAT ARE DENIED BECAUSE THEY ARE FOR A NONCOVERED SERVICE OR BECAUSE THE SERVICE WAS PROVIDED BY A HEALTH CARE PROVIDER NOT ELIGIBLE FOR REIMBURSEMENT;

(III) THAT ARE DENIED AT THEIR INITIAL SUBMISSION BECAUSE OF IMPROPER CODING;

(IV) THAT ARE DENIED AT THEIR INITIAL SUBMISSION BECAUSE OF INCORRECT ENROLLMENT INFORMATION;

(V) THAT ARE NOT PAID WITHIN 30 DAYS AFTER THEIR INITIAL SUBMISSION BECAUSE ADDITIONAL DOCUMENTATION OR INFORMATION IS REQUIRED OR REQUESTED;

(VI) THAT ARE PAID AFTER RECEIPT OF ADDITIONAL DOCUMENTATION OR INFORMATION;

(VII) THAT ARE DENIED AFTER RECEIPT OF ADDITIONAL DOCUMENTATION OR INFORMATION;

(VIII) ON WHICH THE INTEREST PAYMENTS PROVIDED FOR IN § 15-1005 OF THIS SUBTITLE HAVE BEEN PAID, AND THE AGGREGATE AMOUNT OF INTEREST PAID; AND

(IX) THAT ARE DENIED, OR REPORTED TO THE INSURANCE FRAUD DIVISION IN THE ADMINISTRATION, BECAUSE THE CARRIER HAS REASON TO BELIEVE THAT THE CLAIM HAS BEEN SUBMITTED FRAUDULENTLY.

(2) THE RECORD REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION:

(I) SHALL BE IN A FORM REQUIRED BY THE COMMISSIONER; AND

(II) SHALL BE AUDITED ANNUALLY BY A PRIVATE AUDITING FIRM AT THE EXPENSE OF THE CARRIER.

(C) ON OR BEFORE MARCH 1 OF EACH YEAR, EACH CARRIER SHALL SUBMIT TO THE COMMISSIONER AN ANNUAL REPORT THAT CONTAINS:

(1) THE AUDITED RECORD REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR THE PRECEDING CALENDAR YEAR; AND

(2) ANY OTHER INFORMATION THE COMMISSIONER MAY REQUIRE.

(D) AFTER REVIEWING A CARRIER'S ANNUAL REPORT, THE COMMISSIONER MAY:

(1) REQUIRE THE CARRIER TO IMPLEMENT A PLAN OF REMEDIAL ACTION; OR

(2) REQUIRE THAT THE CARRIER'S CLAIMS PROCESSING PROCEDURES BE MONITORED BY A PRIVATE AUDITING FIRM AT THE EXPENSE OF THE CARRIER FOR A PERIOD OF TIME THAT THE COMMISSIONER DEEMS APPROPRIATE.

(E) EACH FINANCIAL EXAMINATION AND MARKET CONDUCT STUDY OF A CARRIER PERFORMED IN ACCORDANCE WITH § 2-205 OF THIS ARTICLE SHALL INCLUDE AN EXAMINATION OF THE CARRIER'S COMPLIANCE WITH THE PROVISIONS OF THIS SECTION.

(F) (1) IN ADDITION TO THE ANNUAL REPORT REQUIRED UNDER SUBSECTION (C) OF THIS SECTION, EACH CARRIER SHALL SUBMIT TO THE COMMISSIONER, AT LEAST QUARTERLY, A REPORT THAT CONTAINS THE INFORMATION DESCRIBED IN SUBSECTION (B)(1)(I) THROUGH (IX) OF THIS SECTION AND ANY OTHER INFORMATION THE COMMISSIONER MAY REQUIRE.

(2) AFTER REVIEWING A REPORT SUBMITTED UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE COMMISSIONER:

(I) MAY REQUIRE AN IMMEDIATE AUDIT OF THE CARRIER BY A PRIVATE AUDITING FIRM AT THE EXPENSE OF THE CARRIER; AND

(II) AFTER REVIEWING THE AUDIT, MAY PROCEED WITH THE REMEDIATION OR MONITORING PROCEDURE PROVIDED FOR IN SUBSECTION (D) OF THIS SECTION.

(G) BASED ON THE INFORMATION CONTAINED IN A REPORT SUBMITTED TO THE COMMISSIONER UNDER THIS SECTION, THE COMMISSIONER MAY FIND A VIOLATION OF § 27-304 OF THIS ARTICLE AND MAY IMPOSE THE PENALTIES PROVIDED IN § 27-305 OF THIS ARTICLE.

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;

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

(16) fail to meet the requirements of Title 15, Subtitle 10B of this article for preauthorization for a health care service; or

(17) fail to comply with the provisions of Title 15, Subtitle 10A of this article.

27-305.

(a) The Commissioner may impose a penalty not exceeding $2,500 for each violation of § 27-303 of this subtitle or a regulation adopted under § 27-303 of this subtitle.

(b) The penalty for a violation of § 27-304 of this subtitle is as provided in §§ 1-301, 4-113, 4-114, and 27-103 of this article.

(c) (1) On finding a violation of this subtitle, the Commissioner may require an insurer or nonprofit health service plan to make restitution to each claimant who has suffered actual economic damage because of the violation.

(2) Restitution may not exceed the amount of actual economic damage sustained, subject to the limits of any applicable policy.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2000.