SENATE BILL 164

Unofficial Copy 2000 Regular Session
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CF 0lr0174

By: **Chairman, Finance Committee (Departmental - Insurance Administration, Maryland)**
Introduced and read first time: January 21, 2000
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance - Internal Appeal and Grievance Processes

FOR the purpose of requiring certain carriers to include certain information in a notice of an adverse decision; requiring certain carriers to include certain information in a notice of a grievance decision; requiring carriers to establish an internal appeal process for use by their members and health care providers for disputes relating to coverage decisions; requiring carriers to provide certain information concerning the internal appeal process to members under certain circumstances; requiring carriers to send members written notice of a coverage decision under certain circumstances; requiring certain carriers to include certain information in a notice of a coverage decision; requiring carriers to meet the burden of persuasion in certain circumstances; requiring the Commissioner to include certain information in a certain notice; authorizing the Commissioner to take certain action against a carrier for certain violations; authorizing the Commissioner to adopt certain regulations; defining certain terms; 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, 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 SEND, WITHIN 5 WORKING DAYS AFTER THE ADVERSE DECISION HAS BEEN MADE, A NOTICE TO THE MEMBER THAT:

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

(2) 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) STATES THE NAME, BUSINESS ADDRESS, AND BUSINESS TELEPHONE NUMBER OF:

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

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

(5) INCLUDES THE FOLLOWING INFORMATION:

(I) 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) 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) THE COMMISSIONER'S ADDRESS, TELEPHONE NUMBER, AND FACSIMILE NUMBER; AND

(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 SEND, WITHIN 5 WORKING DAYS AFTER THE GRIEVANCE DECISION HAS BEEN MADE, A NOTICE TO THE MEMBER THAT:

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

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

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

1. 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. 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) [include] INCLUDES 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 grievance decision;

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. 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) 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 HEALTH CARE SERVICES 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 HEALTH CARE SERVICES SUBJECT TO REGULATION BY THE STATE.

(E) "COMPLAINT" MEANS A PROTEST FILED WITH THE COMMISSIONER INVOLVING A 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 DETERMINATION BY A CARRIER OR A REPRESENTATIVE OF THE CARRIER THAT RESULTS IN NONCOVERAGE OF A HEALTH CARE SERVICE.

(2) "COVERAGE DECISION" INCLUDES PAYMENT OF A CLAIM.

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

(G) "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) "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) (1) "MEMBER" MEANS A PERSON ENTITLED TO HEALTH CARE BENEFITS UNDER A POLICY, PLAN, OR CERTIFICATE 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.

(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.

(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 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.

(F) 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) (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) 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.

(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.

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.