Department of Legislative Services

Maryland General Assembly
2000 Session

FISCAL NOTE
Revised

Senate Bill 164 (Chairman, Finance Committee)
(Departmental - Insurance Administration, Maryland)

Finance

Health Insurance - Internal Appeal and Grievance Processes

This departmental bill requires an insurer, nonprofit health service plan, HMO, or dental plan organization (carrier) to include its internal appeals and grievance information in its initial letter notifying an enrollee of an adverse decision (determinations of medical necessity). The carrier must send the letter within five working days after the adverse decision has been rendered. The bill also repeals the requirement that the carrier send this information to an enrollee within two working days after initial contact with the enrollee.

In addition, the bill requires a carrier to establish an internal complaint procedure for coverage decisions other than determinations of medical necessity.

The bill's requirements for establishing an internal complaint procedure take effect January 1, 2001.

Fiscal Summary

State Effect: Minimal general fund revenue increase from the State's 2% insurance premium tax on for-profit carriers. Minimal special fund revenue increase for the Maryland Insurance Administration from the $125 rate and form filing fee. No effect on expenditures.

Local Effect: None.

Small Business Effect: The Maryland Insurance Administration (MIA) has determined that this bill has minimal or no impact on small business (attached). Legislative Services concurs with this assessment. (The attached assessment does not reflect amendments to the bill.)

Analysis

Bill Summary: Currently, a carrier may often have to send notice of internal appeals information to an enrollee twice within a five-day period. This bill eliminates the first written notification requirement and requires that the carrier first orally communicate the adverse decision to the enrollee.

In addition, the bill specifies appeals information that a carrier must send in writing to an enrollee within five days after an adverse decision has been rendered. A carrier must inform an enrollee (or a health care provider acting in the behalf of the enrollee) of: (1) the bases for the carrier's decision, which must be written in clear, understandable language and include the specific factual reasons for the adverse decision; (2) the standards and interpretive guidelines on which the decision was based; (3) the name, address, and telephone number of the medical director or representative who made the decision; (4) the details of the carrier's internal grievance procedure; (5) the member's right to file a complaint with the Insurance Commissioner within 30 days after receipt of the grievance decision; (6) the right to file a complaint with the Commissioner without first filing a grievance if there is a compelling reason to do so; (7) the Commissioner's address, telephone number, and fax number; (8) a statement that the Health Advocacy Unit is available to assist the enrollee in mediating and filing a grievance under the carrier's internal grievance process; and (9) the address, telephone number, fax number, and e-mail address of the Health Advocacy Unit.

A carrier must send similar appeals and contact information to an enrollee within five working days after rendering a grievance decision.

The bill also establishes a complaint process for coverage decisions. The complaint process allows a member to appeal any coverage decision that is not an adverse decision.
A carrier may use its established internal grievance process for reviewing coverage decisions. The complaint process also includes notification requirements, similar to those required in adverse decisions, advising enrollees of appeals information and their right to file a complaint with the Insurance Commissioner in certain circumstances.

Current Law: If an enrollee contacts the carrier about an adverse decision, the carrier must send grievance process information to the enrollee within two working days. In addition, the carrier must send written grievance process information to the enrollee within five working days after an adverse decision has been rendered. Carriers are required to have an internal appeals process for adverse decisions (determinations of medical necessity).

State Fiscal Effect: Currently, enrollee complaints about coverage decisions are handled by the MIA. MIA would have fewer complaints to arbitrate since the enrollee must first go through the carrier's internal appeals process. No reduction in expenditures is expected, however, because the number of complaints increases annually. MIA may experience an increased volume of contract revision filings as a result of the bill's requirements. Any additional filings could be handled with existing resources.

Additional Information

Prior Introductions: None.

Cross File: HB 405 (Departmental - Insurance Administration, Maryland) - Economic Matters.

Information Source(s): Maryland Insurance Administration, Department of Health and Mental Hygiene (Office of Health Care Quality, Health Care Commission), Department of Legislative Services

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