Department of Legislative Services

Maryland General Assembly
2001 Session

FISCAL NOTE
Revised

Senate Bill 856 (Senator Bromwell)
Finance Economic Matters

Health Insurance - Appeals and Grievances Procedures - Modifications

This bill requires a health insurer, nonprofit health service plan, dental plan organization, or HMO (carrier) to allow a member or health care provider on behalf of a member to file a grievance for at least 180 days after the member receives an adverse decision. Within 30 working days after receipt of a grievance decision, a member who filed the grievance may file a complaint with the Insurance Commissioner for review of the grievance decision. Beginning January 1, 2002, a carrier must submit as part of its quarterly report to the Insurance Commissioner the number of adverse decisions issued by the carrier and the type of service at issue in the adverse decisions.

Fiscal Summary

State Effect: Any additional complaints filed with the Maryland Insurance Administration could be handled with existing resources. Minimal special fund revenue increase for the Maryland Insurance Administration in FY 2002 from the $125 rate and form filing fee.

Local Effect: None.

Small Business Effect: None.

Analysis

Current Law: A carrier must provide an internal grievance process. There is no time provision requirement for filing grievances based on adverse decisions. A member must file a complaint with the Maryland Insurance Administration (MIA) within 30 days after receiving an adverse decision.

State Fiscal Effect: Many carriers limit the time in which a member can appeal an adverse decision to periods shorter than six months. Consequently, these carriers would be required to amend their internal grievance procedures and file the revised documents with MIA. In addition, the increased time period in which to file a grievance could lead to additional grievances filed with carriers and more complaints filed with MIA. It is assumed that the number of additional complaints filed with MIA would be minimal and could be handled with existing resources.

Maryland Insurance Administration Estimate. MIA advises that it will need one investigator to handle additional complaints and one MIA associate to analyze the additional data on adverse decisions that carriers must file with their quarterly report. The Department of Legislative Services disagrees. While over 1,500 complaints were filed in calendar 2000, 511 were determined to be complaints about adverse decisions, of which MIA investigated 255. The bill's provisions only lengthen the time in which a member may file a grievance and do not create any new grounds upon which to grieve. Accordingly, any additional complaints filed with MIA should be minimal and could be handled with existing budgeted resources. In addition, the bill's requirement that a carrier must submit to MIA, as part of its quarterly report, the number of adverse decisions and the type of service at issue in the adverse decisions should not necessitate an additional staff person to analyze and prepare data for the annual report to the General Assembly.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Maryland Insurance Administration, Department of Health and Mental Hygiene (Health Care Commission, Board of Physician Quality Assurance), Department of Budget and Management (Employee Benefits Division), CareFirst BlueCross BlueShield of Maryland, Department of Legislative Services

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