

HOUSE BILL 170

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CF SB 183

By: **The Speaker (By Request – Administration) and Delegates Hammen, Hubbard, Anderson, Arora, Barnes, Cullison, Dumais, Gutierrez, Guzzone, Hucker, A. Kelly, Lee, Morhaim, Nathan–Pulliam, Pena–Melnik, Pendergrass, Reznik, Rosenberg, V. Turner, and Zucker**

Introduced and read first time: January 26, 2011

Assigned to: Health and Government Operations

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Conformity with Federal Law**

3 FOR the purpose of altering the circumstances under which a person has the right to a
4 hearing and the right to an appeal from an action of the Maryland Insurance
5 Commissioner; providing that certain provisions of federal law apply to certain
6 insurers, nonprofit health service plans, and health maintenance organizations;
7 authorizing the Commissioner to enforce certain provisions of law; altering the
8 requirement for certain insurers, nonprofit health service plans, and health
9 maintenance organizations to send a certain notice when a child who is covered
10 under a certain insurance policy or contract reaches a certain age; requiring
11 certain insurers, nonprofit health service plans, and health maintenance
12 organizations to comply with certain loss ratio requirements; authorizing a
13 member’s representative to file a certain grievance, complaint, or appeal;
14 altering the circumstances under which a certain complaint may be filed with
15 the Commissioner; altering requirements for certain filings, timeframes, and
16 evidence of coverage information relating to appeals and grievances; requiring
17 certain carriers to provide certain notices to certain members in a manner
18 described in the Patient Protection and Affordable Care Act; altering the
19 calculation of a minimum participation requirement in the small group health
20 insurance market; requiring the Maryland Health Care Commission to include
21 certain mental health and substance abuse benefits under the Standard Health
22 Benefit Plan; making certain provisions of this Act applicable to health
23 maintenance organizations; altering certain definitions; defining certain terms;
24 making conforming and technical changes; providing for the application of this
25 Act; and generally relating to conformity with federal law relating to health
26 insurance and mental health benefits.

27 BY repealing and reenacting, without amendments,

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



- 1 Article – Insurance
2 Section 1–101(a) and (b)
3 Annotated Code of Maryland
4 (2003 Replacement Volume and 2010 Supplement)
- 5 BY adding to
6 Article – Insurance
7 Section 1–101(b–1)
8 Annotated Code of Maryland
9 (2003 Replacement Volume and 2010 Supplement)
- 10 BY repealing and reenacting, with amendments,
11 Article – Insurance
12 Section 2–210(a) and 2–215(a)
13 Annotated Code of Maryland
14 (2003 Replacement Volume and 2010 Supplement)
- 15 BY adding to
16 Article – Insurance
17 Section 15–137.1, 15–10A–01(m), 15–10A–10, and 15–10D–05
18 Annotated Code of Maryland
19 (2006 Replacement Volume and 2010 Supplement)
- 20 BY repealing and reenacting, with amendments,
21 Article – Insurance
22 Section 15–416, 15–605(c), 15–802(a), 15–10A–01(f) and (m), 15–10A–02,
23 15–10A–03, 15–10A–04(a), 15–10D–01, 15–10D–02, 15–1206(c), and
24 15–1207
25 Annotated Code of Maryland
26 (2006 Replacement Volume and 2010 Supplement)
- 27 BY repealing and reenacting, without amendments,
28 Article – Insurance
29 Section 15–10A–01(a) and (l)
30 Annotated Code of Maryland
31 (2006 Replacement Volume and 2010 Supplement)
- 32 BY repealing and reenacting, with amendments,
33 Article – Health – General
34 Section 19–703.1(a) and 19–732(a)
35 Annotated Code of Maryland
36 (2009 Replacement Volume and 2010 Supplement)
- 37 BY adding to
38 Article – Health –General
39 Section 19–706(kkkk)
40 Annotated Code of Maryland
41 (2009 Replacement Volume and 2010 Supplement)

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

3 **Article – Insurance**

4 1–101.

5 (a) In this article the following words have the meanings indicated.

6 (b) “Administration” means the Maryland Insurance Administration.

7 **(B–1) “AFFORDABLE CARE ACT” MEANS THE FEDERAL PATIENT**
8 **PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY THE FEDERAL**
9 **HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010, AND ANY**
10 **REGULATIONS ADOPTED OR GUIDANCE ISSUED UNDER THE ACTS.**

11 2–210.

12 (a) (1) The Commissioner may hold hearings that the Commissioner
13 considers necessary for any purpose under this article.

14 (2) The Commissioner shall hold a hearing:

15 (i) if required by any provision of this article; or

16 (ii) **EXCEPT AS OTHERWISE PROVIDED IN THIS ARTICLE**, on
17 written demand by a person aggrieved by any act of, threatened act of, or failure to act
18 by the Commissioner or by any report, regulation, or order of the Commissioner,
19 except an order to hold a hearing or an order resulting from a hearing.

20 2–215.

21 (a) An appeal under this subtitle may be taken only from:

22 (1) an order resulting from a hearing; [or]

23 (2) a refusal by the Commissioner to grant a hearing; **OR**

24 **(3) A DECISION ISSUED UNDER TITLE 15, SUBTITLE 10A OF THIS**
25 **ARTICLE.**

26 **15–137.1.**

27 **(A) NOTWITHSTANDING ANY OTHER PROVISIONS OF LAW, THE**
28 **FOLLOWING PROVISIONS OF TITLE I, SUBTITLES A AND C OF THE FEDERAL**

1 **PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY §§ 10101**
2 **AND 10103 OF THAT ACT AND THE FEDERAL HEALTH CARE AND EDUCATION**
3 **RECONCILIATION ACT OF 2010 AND ANY OTHER APPLICABLE REGULATIONS OR**
4 **OTHER FEDERAL REQUIREMENTS, APPLY TO ALL INSURERS, NONPROFIT**
5 **HEALTH SERVICE PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS THAT**
6 **DELIVER OR ISSUE FOR DELIVERY INDIVIDUAL, GROUP, OR BLANKET HEALTH**
7 **INSURANCE POLICIES OR CONTRACTS IN THE STATE:**

8 (1) **COVERAGE OF CHILDREN UP TO THE AGE OF 26 YEARS;**

9 (2) **PREEXISTING CONDITION EXCLUSIONS;**

10 (3) **POLICY RESCISSIONS;**

11 (4) **BONA FIDE WELLNESS PROGRAMS;**

12 (5) **LIFETIME LIMITS;**

13 (6) **ANNUAL LIMITS FOR ESSENTIAL BENEFITS;**

14 (7) **WAITING PERIODS;**

15 (8) **DESIGNATION OF PRIMARY CARE PROVIDERS;**

16 (9) **ACCESS TO OBSTETRICAL AND GYNECOLOGICAL SERVICES;**

17 (10) **EMERGENCY SERVICES;**

18 (11) **SUMMARY OF BENEFITS AND COVERAGE EXPLANATION;**

19 (12) **MINIMUM LOSS RATIO REQUIREMENTS AND PREMIUM**
20 **REBATES; AND**

21 (13) **DISCLOSURE OF INFORMATION.**

22 (B) **THE COMMISSIONER MAY ENFORCE THIS SECTION UNDER ANY**
23 **APPLICABLE PROVISIONS OF THIS ARTICLE.**

24 15-416.

25 (a) This section applies to insurers, nonprofit health service plans, and
26 health maintenance organizations that deliver or issue for delivery in the State
27 individual, group, or blanket health insurance policies and contracts.

1 (b) At least 60 days before a child who is covered under a parent's individual,
2 group, or blanket health insurance policy or contract [turns 18 years of age] **REACHES**
3 **THE LIMITING AGE UNDER THE POLICY OR CONTRACT**, an entity subject to this
4 section shall:

5 (1) notify the parent of criteria under which a child may remain
6 eligible for coverage as a dependent under the policy or contract; and

7 (2) provide information regarding:

8 (i) any other policies that may be available to the child from the
9 entity; and

10 (ii) the availability of additional information from the
11 Administration regarding individual policies in the State.

12 (c) The Commissioner shall establish and publish by bulletin the notice to be
13 given under this section.

14 15-605.

15 (c) (1) [For a health benefit plan that is issued under Subtitle 12 of this
16 title, the Commissioner may require the insurer, nonprofit health service plan, or
17 health maintenance organization to file new rates if the loss ratio is less than 75%.

18 (2) (i) Subject to subparagraph (ii) of this paragraph, for a health
19 benefit plan that is issued to individuals the Commissioner may require the insurer,
20 nonprofit health service plan, or health maintenance organization to file new rates if
21 the loss ratio is less than 60%.

22 (ii) Subparagraph (i) of this paragraph does not apply to an
23 insurance product that:

24 1. is listed under § 15-1201(f)(3) of this title; or

25 2. is nonrenewable and has a policy term of no more
26 than 6 months.

27 (iii) The Commissioner may establish a loss ratio for each
28 insurance product described in subparagraph (ii)1 and 2 of this paragraph.]

29 **(I) AN AUTHORIZED INSURER, NONPROFIT HEALTH**
30 **SERVICE PLAN, AND HEALTH MAINTENANCE ORGANIZATION REQUIRED TO**
31 **SUBMIT AN ANNUAL REPORT UNDER SUBSECTION (A)(1) OF THIS SECTION**
32 **SHALL COMPLY WITH THE LOSS RATIO REQUIREMENTS OF SECTIONS 1001(5)**
33 **AND 10101(F) OF THE AFFORDABLE CARE ACT, WHICH AMEND SECTION 2718**
34 **OF THE PUBLIC HEALTH SERVICE ACT.**

1 **(II) THE COMMISSIONER MAY REQUIRE AN INSURER, A**
2 **NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE**
3 **ORGANIZATION TO FILE NEW RATES IF THE LOSS RATIO IS LESS THAN THAT**
4 **REQUIRED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.**

5 **[(3)] (2)** The authority of the Commissioner under [paragraphs (1)
6 and (2)] **PARAGRAPH (1)** of this subsection to require an insurer, nonprofit health
7 service plan, or health maintenance organization to file new rates based on loss ratio:

8 (i) is in addition to any other authority of the Commissioner
9 under this article to require that rates not be excessive, inadequate, or unfairly
10 discriminatory; and

11 (ii) does not limit any existing authority of the Commissioner to
12 determine whether a rate is excessive.

13 **[(4)] (3)** (i) In determining whether to require an insurer to file
14 new rates under this subsection, the Commissioner may consider the amount of health
15 insurance premiums earned in the State on individual policies in proportion to the
16 total health insurance premiums earned in the State for the insurer.

17 (ii) The insurer shall provide to the Commissioner the
18 information necessary to determine the proportion of individual health insurance
19 premiums to total health insurance premiums as provided under this paragraph.

20 **[(5)] (4)** The Secretary of Health and Mental Hygiene, in
21 consultation with the Commissioner and in accordance with their memorandum of
22 understanding, may adjust capitation payments for a managed care organization or
23 for the Maryland Medical Assistance Program of a managed care organization that is a
24 certified health maintenance organization[:

25 (i) if the loss ratio is less than 80% during calendar year 1997;
26 and

27 (ii) during each subsequent calendar year] if the loss ratio is
28 less than 85%.

29 **[(6)] (5)** A loss ratio reported under paragraph **[(5)] (4)** of this
30 subsection shall be calculated separately and may not be part of another loss ratio
31 reported under this section.

32 **[(7)] (6)** Any rebate received by a managed care organization may
33 not be considered part of the loss ratio of the managed care organization.

1 **[(8)] (7)** If the Secretary of Health and Mental Hygiene adjusts
2 capitation payments for a managed care organization or a certified health
3 maintenance organization under paragraph **[(5)] (4)** of this subsection, the managed
4 care organization or certified health maintenance organization may:

5 (i) appeal the decision of the Secretary to the Board of Review
6 established under Title 2, Subtitle 2 of the Health – General Article; and

7 (ii) take any further appeal allowed by the Administrative
8 Procedure Act under Title 10, Subtitle 2 of the State Government Article.

9 15–802.

10 (a) (1) In this section the following words have the meanings indicated.

11 (2) “Alcohol abuse” has the meaning stated in § 8–101 of the Health –
12 General Article.

13 (3) “Drug abuse” has the meaning stated in § 8–101 of the Health –
14 General Article.

15 (4) “Health benefit plan” has the meaning stated in § 15–1401 of this
16 title.

17 (5) “Large employer” means an employer that has more than 50
18 employees and is not a small employer.

19 (6) “Managed care system” means a system of cost containment
20 methods that a carrier uses to review and preauthorize a treatment plan developed by
21 a health care provider for a covered individual in order to control utilization, quality,
22 and claims.

23 (7) “Partial hospitalization” means the provision of medically directed
24 intensive or intermediate short-term treatment:

25 (i) to an insured, subscriber, or member;

26 (ii) in a licensed or certified facility or program;

27 (iii) for mental illness, emotional disorders, drug abuse, or
28 alcohol abuse; and

29 (iv) for a period of less than 24 hours but more than 4 hours in a
30 day.

31 (8) “Small employer” [has the meaning stated in § 15–1201 of this
32 title] **MEANS AN EMPLOYER THAT:**

1 **(I) EMPLOYED AN AVERAGE OF AT LEAST TWO, BUT NOT**
2 **MORE THAN 50 EMPLOYEES ON BUSINESS DAYS DURING THE PRECEDING**
3 **CALENDAR YEAR; AND**

4 **(II) EMPLOYS AT LEAST TWO EMPLOYEES ON THE FIRST DAY**
5 **OF THE PLAN YEAR.**

6 15–10A–01.

7 (a) In this subtitle the following words have the meanings indicated.

8 (f) “Grievance” means a protest filed by a member, **A MEMBER’S**
9 **REPRESENTATIVE**, or a health care provider on behalf of a member with a carrier
10 through the carrier’s internal grievance process regarding an adverse decision
11 concerning the member.

12 (1) (1) “Member” means a person entitled to health care benefits under a
13 policy, plan, or certificate issued or delivered in the State by a carrier.

14 (2) “Member” includes:

15 (i) a subscriber; and

16 (ii) unless preempted by federal law, a Medicare recipient.

17 (3) “Member” does not include a Medicaid recipient.

18 **(M) “MEMBER’S REPRESENTATIVE” MEANS AN INDIVIDUAL WHO HAS**
19 **BEEN AUTHORIZED BY THE MEMBER TO FILE A GRIEVANCE OR A COMPLAINT ON**
20 **THE MEMBER’S BEHALF.**

21 **[(m)] (N)** “Private review agent” has the meaning stated in § 15–10B–01 of
22 this title.

23 15–10A–02.

24 (a) Each carrier shall establish an internal grievance process for its
25 members.

26 (b) (1) An internal grievance process shall meet the same requirements
27 established under Subtitle 10B of this title.

28 (2) In addition to the requirements of Subtitle 10B of this title, an
29 internal grievance process established by a carrier under this section shall:

1 (i) include an expedited procedure for use in an emergency case
2 for purposes of rendering a grievance decision within 24 hours of the date a grievance
3 is filed with the carrier;

4 (ii) provide that a carrier render a final decision in writing on a
5 grievance within 30 working days after the date on which the grievance is filed unless:

6 1. the grievance involves an emergency case under item
7 (i) of this paragraph;

8 2. the member, **THE MEMBER'S REPRESENTATIVE**, or
9 a health care provider filing a grievance on behalf of a member agrees in writing to an
10 extension for a period of no longer than 30 working days; or

11 3. the grievance involves a retrospective denial under
12 item (iv) of this paragraph;

13 (iii) allow a grievance to be filed on behalf of a member by a
14 health care provider **OR THE MEMBER'S REPRESENTATIVE**;

15 (iv) provide that a carrier render a final decision in writing on a
16 grievance within 45 working days after the date on which the grievance is filed when
17 the grievance involves a retrospective denial; and

18 (v) for a retrospective denial, allow a member, **THE MEMBER'S**
19 **REPRESENTATIVE**, or a health care provider on behalf of a member to file a grievance
20 for at least 180 days after the member receives an adverse decision.

21 (3) For purposes of using the expedited procedure for an emergency
22 case that a carrier is required to include under paragraph (2)(i) of this subsection, the
23 Commissioner shall define by regulation the standards required for a grievance to be
24 considered an emergency case.

25 (c) Except as provided in subsection (d) of this section, the carrier's internal
26 grievance process shall be exhausted prior to filing a complaint with the Commissioner
27 under this subtitle.

28 (d) (1) (i) A member, **THE MEMBER'S REPRESENTATIVE**, or a health
29 care provider filing a complaint on behalf of a member may file a complaint with the
30 Commissioner without first filing a grievance with a carrier and receiving a final
31 decision on the grievance if:

32 1. **THE CARRIER WAIVES THE REQUIREMENT THAT**
33 **THE CARRIER'S INTERNAL GRIEVANCE PROCESS BE EXHAUSTED BEFORE FILING**
34 **A COMPLAINT WITH THE COMMISSIONER**;

1 **2. THE CARRIER HAS FAILED TO COMPLY WITH ANY**
2 **OF THE REQUIREMENTS OF THE INTERNAL GRIEVANCE PROCESS AS DESCRIBED**
3 **IN THIS SECTION; OR**

4 **3. the member, THE MEMBER'S REPRESENTATIVE, or**
5 **the health care provider provides sufficient information and supporting documentation**
6 **in the complaint that demonstrates a compelling reason to do so.**

7 (ii) The Commissioner shall define by regulation the standards
8 that the Commissioner shall use to decide what demonstrates a compelling reason
9 under subparagraph (i) of this paragraph.

10 (2) Subject to subsections (b)(2)(ii) and (h) of this section, a member, A
11 **MEMBER'S REPRESENTATIVE**, or a health care provider may file a complaint with
12 the Commissioner if the member, **THE MEMBER'S REPRESENTATIVE**, or the health
13 care provider does not receive a grievance decision from the carrier on or before the
14 30th working day on which the grievance is filed.

15 (3) Whenever the Commissioner receives a complaint under paragraph
16 (1) or (2) of this subsection, the Commissioner shall notify the carrier that is the
17 subject of the complaint within 5 working days after the date the complaint is filed
18 with the Commissioner.

19 (e) Each carrier shall:

20 (1) file for review with the Commissioner and submit to the Health
21 Advocacy Unit a copy of its internal grievance process established under this subtitle;
22 and

23 (2) [update the initial filing annually to reflect any changes made]
24 **FILE ANY REVISION TO THE INTERNAL GRIEVANCE PROCESS WITH THE**
25 **COMMISSIONER AT LEAST 30 DAYS BEFORE ITS INTENDED USE.**

26 (f) For nonemergency cases, when a carrier renders an adverse decision, the
27 carrier shall:

28 (1) document the adverse decision in writing after the carrier has
29 provided oral communication of the decision to the member, **THE MEMBER'S**
30 **REPRESENTATIVE**, or the health care provider acting on behalf of the member; and

31 (2) send, within 5 working days after the adverse decision has been
32 made, a written notice to the member, **THE MEMBER'S REPRESENTATIVE**, and a
33 health care provider acting on behalf of the member that:

34 (i) states in detail in clear, understandable language the
35 specific factual bases for the carrier's decision;

1 (ii) references the specific criteria and standards, including
2 interpretive guidelines, on which the decision was based, and may not solely use
3 generalized terms such as “experimental procedure not covered”, “cosmetic procedure
4 not covered”, “service included under another procedure”, or “not medically necessary”;

5 (iii) states the name, business address, and business telephone
6 number of:

7 1. the medical director or associate medical director, as
8 appropriate, who made the decision if the carrier is a health maintenance
9 organization; or

10 2. the designated employee or representative of the
11 carrier who has responsibility for the carrier’s internal grievance process if the carrier
12 is not a health maintenance organization;

13 (iv) gives written details of the carrier’s internal grievance
14 process and procedures under this subtitle; and

15 (v) includes the following information:

16 1. that the member, **THE MEMBER’S**
17 **REPRESENTATIVE**, or a health care provider on behalf of the member has a right to
18 file a complaint with the Commissioner within [30 working days] **4 MONTHS** after
19 receipt of a carrier’s grievance decision;

20 2. that a complaint may be filed without first filing a
21 grievance if the member, **THE MEMBER’S REPRESENTATIVE**, or a health care
22 provider filing a grievance on behalf of the member can demonstrate a compelling
23 reason to do so as determined by the Commissioner;

24 3. the Commissioner’s address, telephone number, and
25 facsimile number;

26 4. a statement that the Health Advocacy Unit is
27 available to assist the member in both mediating and filing a grievance under the
28 carrier’s internal grievance process; and

29 5. the address, telephone number, facsimile number, and
30 electronic mail address of the Health Advocacy Unit.

31 (g) If within 5 working days after a member, **THE MEMBER’S**
32 **REPRESENTATIVE**, or a health care provider, who has filed a grievance on behalf of a
33 member, files a grievance with the carrier, and if the carrier does not have sufficient
34 information to complete its internal grievance process, the carrier shall:

1 (1) notify the member, **THE MEMBER'S REPRESENTATIVE**, or **THE**
2 health care provider that it cannot proceed with reviewing the grievance unless
3 additional information is provided; and

4 (2) assist the member, **THE MEMBER'S REPRESENTATIVE**, or **THE**
5 health care provider in gathering the necessary information without further delay.

6 (h) A carrier may extend the 30-day or 45-day period required for making a
7 final grievance decision under subsection (b)(2)(ii) of this section with the written
8 consent of the member, **THE MEMBER'S REPRESENTATIVE**, or the health care
9 provider who filed the grievance on behalf of the member.

10 (i) (1) For nonemergency cases, when a carrier renders a grievance
11 decision, the carrier shall:

12 (i) document the grievance decision in writing after the carrier
13 has provided oral communication of the decision to the member, **THE MEMBER'S**
14 **REPRESENTATIVE**, or the health care provider acting on behalf of the member; and

15 (ii) send, within 5 working days after the grievance decision has
16 been made, a written notice to the member, **THE MEMBER'S REPRESENTATIVE**, and
17 a health care provider acting on behalf of the member that:

18 1. states in detail in clear, understandable language the
19 specific factual bases for the carrier's decision;

20 2. references the specific criteria and standards,
21 including interpretive guidelines, on which the grievance decision was based;

22 3. states the name, business address, and business
23 telephone number of:

24 A. the medical director or associate medical director, as
25 appropriate, who made the grievance decision if the carrier is a health maintenance
26 organization; or

27 B. the designated employee or representative of the
28 carrier who has responsibility for the carrier's internal grievance process if the carrier
29 is not a health maintenance organization; and

30 4. includes the following information:

31 A. that the member or **THE MEMBER'S**
32 **REPRESENTATIVE** has a right to file a complaint with the Commissioner within [30
33 working days] **4 MONTHS** after receipt of a carrier's grievance decision; and

1 B. the Commissioner's address, telephone number, and
2 facsimile number.

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

7 (j) (1) For an emergency case under subsection (b)(2)(i) of this section,
8 within 1 day after a decision has been orally communicated to the member, **THE**
9 **MEMBER'S REPRESENTATIVE**, or **THE** health care provider, the carrier shall send
10 notice in writing of any adverse decision or grievance decision to:

11 (i) the member **AND THE MEMBER'S REPRESENTATIVE, IF**
12 **ANY**; and

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

15 (2) A notice required to be sent under paragraph (1) of this subsection
16 shall include the following:

17 (i) for an adverse decision, the information required under
18 subsection (f) of this section; and

19 (ii) for a grievance decision, the information required under
20 subsection (i) of this section.

21 (k) **(1)** Each carrier shall include the information required by subsection
22 (f)(2)(iii), (iv), and (v) of this section in the policy, plan, certificate, enrollment
23 materials, or other evidence of coverage that the carrier provides to a member at the
24 time of the member's initial coverage or renewal of coverage.

25 **(2) EACH CARRIER SHALL INCLUDE AS PART OF THE**
26 **INFORMATION REQUIRED BY PARAGRAPH (1) OF THIS SUBSECTION A**
27 **STATEMENT INDICATING THAT, WHEN FILING A COMPLAINT WITH THE**
28 **COMMISSIONER, THE MEMBER OR THE MEMBER'S REPRESENTATIVE WILL BE**
29 **REQUIRED TO AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS OF THE**
30 **MEMBER THAT MAY BE REQUIRED TO BE REVIEWED FOR THE PURPOSE OF**
31 **REACHING A DECISION ON THE COMPLAINT.**

32 (l) (1) Nothing in this subtitle prohibits a carrier from delegating its
33 internal grievance process to a private review agent that has a certificate issued under
34 Subtitle 10B of this title and is acting on behalf of the carrier.

35 (2) If a carrier delegates its internal grievance process to a private
36 review agent, the carrier shall be:

1 (i) bound by the grievance decision made by the private review
2 agent acting on behalf of the carrier; and

3 (ii) responsible for a violation of any provision of this subtitle
4 regardless of the delegation made by the carrier under paragraph (1) of this
5 subsection.

6 15–10A–03.

7 (a) (1) Within [30 working days] **4 MONTHS** after the date of receipt of
8 **AN ADVERSE DECISION OR** a grievance decision, a member, **A MEMBER’S**
9 **REPRESENTATIVE**, or a health care provider, who filed the grievance on behalf of the
10 member under § 15–10A–02(b)(2)(iii) of this subtitle, may file a complaint with the
11 Commissioner [for review of the grievance decision].

12 (2) Whenever the Commissioner receives a complaint under this
13 subsection, the Commissioner shall notify the carrier that is the subject of the
14 complaint within 5 working days after the date the complaint is filed with the
15 Commissioner.

16 (3) Except for an emergency case under subsection (b)(1)(ii) of this
17 section, the carrier that is the subject of a complaint filed under paragraph (1) of this
18 subsection shall provide to the Commissioner any information requested by the
19 Commissioner no later than 7 working days from the date the carrier receives the
20 request for information.

21 (b) (1) In developing procedures to be used in reviewing and deciding
22 complaints, the Commissioner shall:

23 (i) allow a health care provider to file a complaint on behalf of a
24 member; and

25 (ii) establish an expedited procedure for use in an emergency
26 case for the purpose of making a final decision on a complaint within 24 hours after
27 the complaint is filed with the Commissioner.

28 (2) For purposes of using the expedited procedure for an emergency
29 case under paragraph (1)(ii) of this subsection, the Commissioner shall define by
30 regulation the standards required for a grievance to be considered an emergency case.

31 (c) (1) Except as provided in paragraph (2) of this subsection and except
32 for an emergency case under subsection (b)(1)(ii) of this section, the Commissioner
33 shall make a final decision on a complaint:

34 (i) within [30 working] **45** days after a complaint regarding a
35 pending health care service is filed; and

1 (ii) within 45 [working] days after a complaint is filed regarding
2 a retrospective denial of services already provided.

3 (2) The Commissioner may extend the period within which a final
4 decision is to be made under paragraph (1) of this subsection for up to an additional 30
5 working days if:

6 (i) the Commissioner has not yet received information
7 requested by the Commissioner; and

8 (ii) the information requested is necessary for the Commissioner
9 to render a final decision on the complaint.

10 (d) In cases considered appropriate by the Commissioner, the Commissioner
11 may seek advice from an independent review organization or medical expert, as
12 provided in § 15–10A–05 of this subtitle, for complaints filed with the Commissioner
13 under this subtitle that involve a question of whether a health care service provided or
14 to be provided to a member is medically necessary.

15 (e) (1) A carrier shall have the burden of persuasion that its adverse
16 decision or grievance decision, as applicable, is correct[:

17 (i)] during the review of a complaint by the Commissioner or a
18 designee of the Commissioner[; and

19 (ii) in any hearing held in accordance with § 2–210 of this
20 article].

21 (2) As part of the review of a complaint, the Commissioner or a
22 designee of the Commissioner may consider all of the facts of the case and any other
23 evidence that the Commissioner or designee of the Commissioner considers
24 appropriate.

25 (3) As required under § 15–10A–02(i) of this subtitle, the carrier's
26 adverse decision or grievance decision shall state in detail in clear, understandable
27 language the factual bases for the decision and reference the specific criteria and
28 standards, including interpretive guidelines on which the decision was based.

29 (4) (i) Except as provided in subparagraph (ii) of this paragraph, in
30 responding to a complaint, a carrier may not rely on any basis not stated in its adverse
31 decision or grievance decision.

32 (ii) The Commissioner may allow a carrier, a member, A
33 **MEMBER'S REPRESENTATIVE**, or a health care provider filing a complaint on behalf
34 of a member to provide additional information as may be relevant for the
35 Commissioner to make a final decision on the complaint.

1 **(III) THE COMMISSIONER SHALL ALLOW THE MEMBER, THE**
2 **MEMBER'S REPRESENTATIVE, OR THE HEALTH CARE PROVIDER FILING A**
3 **COMPLAINT ON BEHALF OF THE MEMBER AT LEAST 5 WORKING DAYS TO**
4 **PROVIDE THE ADDITIONAL INFORMATION DESCRIBED IN SUBPARAGRAPH (II)**
5 **OF THIS PARAGRAPH.**

6 **[(iii)] (IV)** The Commissioner's use of additional information
7 may not delay the Commissioner's decision on the complaint by more than 5 working
8 days.

9 (f) The Commissioner may request the member that filed the complaint or a
10 legally authorized designee of the member to sign a consent form authorizing the
11 release of the member's medical records to the Commissioner or the Commissioner's
12 designee that are needed in order for the Commissioner to make a final decision on the
13 complaint.

14 15-10A-04.

15 (a) The Commissioner shall:

16 (1) notwithstanding the provisions of § 15-10A-03(c)(1)(ii) of this
17 subtitle, for the purpose of making final decisions on complaints, prioritize complaints
18 regarding pending health care services over complaints regarding health care services
19 already delivered;

20 (2) make and issue in writing a final decision on all complaints filed
21 with the Commissioner under this subtitle that are within the Commissioner's
22 jurisdiction; and

23 (3) provide notice in writing to all parties to a complaint [of the
24 opportunity and time period for requesting a hearing to be held in accordance with §
25 2-210 of this article] **THAT THE FINAL DECISION:**

26 **(I) IS NOT SUBJECT TO A REQUEST FOR A HEARING UNDER**
27 **THIS SUBTITLE; AND**

28 **(II) IS SUBJECT TO A RIGHT TO FILE A PETITION FOR**
29 **JUDICIAL REVIEW UNDER § 2-215 OF THIS ARTICLE.**

30 15-10A-10.

31 **A CARRIER SHALL PROVIDE THE NOTICES REQUIRED TO BE PROVIDED TO**
32 **MEMBERS UNDER THIS SUBTITLE IN A CULTURALLY AND LINGUISTICALLY**
33 **APPROPRIATE MANNER AS DESCRIBED IN THE AFFORDABLE CARE ACT.**

1 15-10D-01.

2 (a) In this subtitle the following words have the meanings indicated.

3 (b) "Appeal" means a protest filed by a member, **A MEMBER'S**
4 **REPRESENTATIVE**, or a health care provider with a carrier under its internal appeal
5 process regarding a coverage decision concerning a member.

6 (c) "Appeal decision" means a final determination by a carrier that arises
7 from an appeal filed with the carrier under its appeal process regarding a coverage
8 decision concerning a member.

9 (d) "Carrier" means a person that offers a health benefit plan and is:

10 (1) an authorized insurer that provides health insurance in 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 Title 15,
15 Subtitle 1 of the Health – General Article, any other person that offers a health benefit
16 plan subject to regulation by the State.

17 (e) "Complaint" means a protest filed with the Commissioner involving a
18 coverage decision other than that which is covered by Subtitle 10A of this title.

19 (f) (1) "Coverage decision" means:

20 **(I)** an initial determination by a carrier or a representative of
21 the carrier that results in noncoverage of a health care service;

22 **(II)** **A DETERMINATION BY A CARRIER THAT AN INDIVIDUAL**
23 **IS NOT ELIGIBLE FOR COVERAGE UNDER THE CARRIER'S HEALTH BENEFIT**
24 **PLAN; OR**

25 **(III)** **ANY DETERMINATION BY A CARRIER THAT RESULTS IN**
26 **THE RESCISSION OF AN INDIVIDUAL'S COVERAGE UNDER A HEALTH BENEFIT**
27 **PLAN.**

28 (2) "Coverage decision" includes nonpayment of all or any part of a
29 claim.

30 (3) "Coverage decision" does not include:

1 (i) an adverse decision as defined in § 15–10A–01(b) of this
2 title; or

3 (ii) a pharmacy inquiry.

4 (g) “Designee of the Commissioner” means any person to whom the
5 Commissioner has delegated the authority to review and decide complaints filed under
6 this subtitle, including an administrative law judge to whom the authority to conduct
7 a hearing has been delegated for recommended or final decision.

8 (h) (1) “Health benefit plan” means:

9 (i) a hospital or medical policy or contract, including a policy or
10 contract issued under a multiple employer trust or association;

11 (ii) a hospital or medical policy or contract issued by a nonprofit
12 health service plan;

13 (iii) a health maintenance organization contract; or

14 (iv) a dental plan organization contract.

15 (2) “Health benefit plan” does not include one or more, or any
16 combination of the following:

17 (i) long–term care insurance;

18 (ii) disability insurance;

19 (iii) accidental travel and accidental death and dismemberment
20 insurance;

21 (iv) credit health insurance;

22 (v) a health benefit plan issued by a managed care organization,
23 as defined in Title 15, Subtitle 1 of the Health – General Article;

24 (vi) disease–specific insurance; or

25 (vii) fixed indemnity insurance.

26 (i) “Health care provider” means:

27 (1) an individual who is licensed under the Health Occupations Article
28 to provide health care services in the ordinary course of business or practice of a
29 profession and is a treating provider of the member; or

1 (2) a hospital, as defined in § 19–301 of the Health – General Article.

2 (j) “Health care service” means a health or medical care procedure or service
3 rendered by a health care provider that:

4 (1) provides testing, diagnosis, or treatment of a human disease or
5 dysfunction; or

6 (2) dispenses drugs, medical devices, medical appliances, or medical
7 goods for the treatment of a human disease or dysfunction.

8 (k) (1) “Member” means a person entitled to health care services under a
9 policy, plan, or contract issued or delivered in the State by a carrier.

10 (2) “Member” includes:

11 (i) a subscriber; and

12 (ii) unless preempted by federal law, a Medicare recipient.

13 (3) “Member” does not include a Medicaid recipient.

14 **(L) “MEMBER’S REPRESENTATIVE” MEANS AN INDIVIDUAL WHO HAS**
15 **BEEN AUTHORIZED BY THE MEMBER TO FILE AN APPEAL OR A COMPLAINT ON**
16 **BEHALF OF THE MEMBER.**

17 **[(l)] (M)** “Pharmacy benefits manager” has the meaning stated in § 15–1601
18 of this title.

19 **[(m)] (N)** “Pharmacy inquiry” means an inquiry submitted by a pharmacist
20 or pharmacy on behalf of a member to a carrier or a pharmacy benefits manager at the
21 point of sale about the scope of pharmacy coverage, pharmacy benefit design, or
22 formulary under a health benefit plan.

23 15–10D–02.

24 (a) (1) Each carrier shall establish an internal appeal process for use by
25 its members, **ITS MEMBERS’ REPRESENTATIVES**, and health care providers to
26 dispute coverage decisions made by the carrier.

27 (2) The carrier may use the internal grievance process established
28 under Subtitle 10A of this title to comply with the requirement of paragraph (1) of this
29 subsection.

30 (b) **[An internal appeal process established by a] A** carrier under this section
31 shall **[provide that a carrier]** render a final decision in writing to a member, **A**

1 **MEMBER'S REPRESENTATIVE**, and a health care provider acting on behalf of the
2 member[,] within 60 working days after the date on which the appeal is filed.

3 (c) Except as provided in subsection (d) of this section, the carrier's internal
4 appeal process shall be exhausted prior to filing a complaint with the Commissioner
5 under this subtitle.

6 (d) A member, **A MEMBER'S REPRESENTATIVE**, or a health care provider
7 filing a complaint on behalf of a member may file a complaint with the Commissioner
8 without first filing an appeal with a carrier only if the coverage decision involves an
9 urgent medical condition, as defined by regulation adopted by the Commissioner, for
10 which care has not been rendered.

11 (e) (1) Within 30 calendar days after a coverage decision has been made, a
12 carrier shall send a written notice of the coverage decision to the member **AND THE**
13 **MEMBER'S REPRESENTATIVE, IF ANY**, and, in the case of a health maintenance
14 organization, the treating health care provider.

15 (2) Notice of the coverage decision required to be sent under
16 paragraph (1) of this subsection shall:

17 (i) state in detail in clear, understandable language, the
18 specific factual bases for the carrier's decision; and

19 (ii) include the following information:

20 1. that the member, **THE MEMBER'S**
21 **REPRESENTATIVE**, or a health care provider acting on behalf of the member[,] has a
22 right to file an appeal with the carrier;

23 2. that the member, **THE MEMBER'S**
24 **REPRESENTATIVE**, or a health care provider acting on behalf of the member[,] may
25 file a complaint with the Commissioner without first filing an appeal, if the coverage
26 decision involves an urgent medical condition for which care has not been rendered;

27 3. the Commissioner's address, telephone number, and
28 facsimile number;

29 4. that the Health Advocacy Unit is available to assist
30 the member **OR THE MEMBER'S REPRESENTATIVE** in both mediating and filing an
31 appeal under the carrier's internal appeal process; and

32 5. the address, telephone number, facsimile number, and
33 electronic mail address of the Health Advocacy Unit.

34 (f) (1) Within 30 calendar days after the appeal decision has been made,
35 each carrier shall send to the member, **THE MEMBER'S REPRESENTATIVE**, and the

1 health care provider acting on behalf of the member[,] a written notice of the appeal
2 decision.

3 (2) Notice of the appeal decision required to be sent under paragraph
4 (1) of this subsection shall:

5 (i) state in detail in clear, understandable language the specific
6 factual bases for the carrier's decision; and

7 (ii) include the following information:

8 1. that the member, **THE MEMBER'S**
9 **REPRESENTATIVE**, or a health care provider acting on behalf of the member[,] has a
10 right to file a complaint with the Commissioner within [60 working days] **4 MONTHS**
11 after receipt of a carrier's appeal decision; and

12 2. the Commissioner's address, telephone number, and
13 facsimile number.

14 (g) The Commissioner may request the member that filed the complaint or a
15 legally authorized designee of the member to sign a consent form authorizing the
16 release of the member's medical records to the Commissioner or the Commissioner's
17 designee that are needed in order for the Commissioner to make a final decision on the
18 complaint.

19 (h) (1) A carrier shall have the burden of persuasion that its coverage
20 decision or appeal decision, as applicable, is correct:

21 (i) during the review of a complaint by the Commissioner or a
22 designee of the Commissioner; and

23 (ii) in any hearing held in accordance with Title 10, Subtitle 2 of
24 the State Government Article to contest a final decision of the Commissioner made
25 and issued under this subtitle.

26 (2) As part of the review of a complaint, the Commissioner or a
27 designee of the Commissioner may consider all of the facts of the case and any other
28 evidence that the Commissioner or designee of the Commissioner considers
29 appropriate.

30 (i) The Commissioner shall:

31 (1) make and issue in writing a final decision on all complaints filed
32 with the Commissioner under this subtitle that are within the Commissioner's
33 jurisdiction; and

1 (2) provide notice in writing to all parties to a complaint of the
2 opportunity and time period for requesting a hearing to be held in accordance with
3 Title 10, Subtitle 2 of the State Government Article to contest a final decision of the
4 Commissioner made and issued under this subtitle.

5 **15-10D-05.**

6 **A CARRIER SHALL PROVIDE THE NOTICES REQUIRED TO BE PROVIDED TO**
7 **MEMBERS UNDER THIS SUBTITLE IN A CULTURALLY AND LINGUISTICALLY**
8 **APPROPRIATE MANNER AS DESCRIBED IN THE AFFORDABLE CARE ACT.**

9 15-1206.

10 (c) (1) Subject to the approval of the Commissioner and as provided under
11 this subsection and § 15-1209(d) of this subtitle, a carrier may impose reasonable
12 minimum participation requirements.

13 (2) A carrier may not impose a requirement for minimum participation
14 by the eligible employees of a small employer that is greater than 75%.

15 (3) In applying a minimum participation requirement to determine
16 whether the applicable percentage of participation is met, a carrier may not consider
17 as eligible employees:

18 (I) those who have group spousal coverage under a public or
19 private plan of health insurance or another employer's health benefit arrangement,
20 including Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or
21 exceeding the benefits provided under the Standard Plan; **OR**

22 (II) **EMPLOYEES WHO ARE UNDER THE AGE OF 26 YEARS**
23 **WHO ARE COVERED UNDER THEIR PARENT'S HEALTH BENEFIT PLAN.**

24 (4) A carrier may not impose a minimum participation requirement for
25 a small employer group if any member of the group participates in a medical savings
26 account.

27 15-1207.

28 (a) In accordance with Title 19, Subtitle 1 of the Health – General Article,
29 the Commission shall adopt regulations that specify:

30 (1) the Comprehensive Standard Health Benefit Plan to apply under
31 this subtitle; and

32 (2) the requirements for a wellness benefit offered by a carrier to apply
33 under this subtitle.

1 (b) (1) Subject to paragraph (2) of this subsection, the Commission shall
2 exclude or limit benefits or adjust cost-sharing arrangements in the Standard Plan if
3 the average rate for the Standard Plan exceeds 10% of the average annual wage in the
4 State.

5 (2) The Commission annually shall determine the average rate for the
6 Standard Plan by using the average rate submitted by each carrier that offers the
7 Standard Plan.

8 (c) In establishing benefits, the Commission shall judge preventive services,
9 medical treatments, procedures, and related health services based on:

10 (1) their effectiveness in improving the health status of individuals;

11 (2) their impact on maintaining and improving health and on reducing
12 the unnecessary consumption of health care services; and

13 (3) their impact on the affordability of health care coverage.

14 (d) The Commission may exclude:

15 (1) a health care service, benefit, coverage, or reimbursement for
16 covered health care services that is required under this article or the Health – General
17 Article to be provided or offered in a health benefit plan that is issued or delivered in
18 the State by a carrier; or

19 (2) reimbursement required by statute, by a health benefit plan for a
20 service when that service is performed by a health care provider who is licensed under
21 the Health Occupations Article and whose scope of practice includes that service.

22 **(E) THE COMMISSION SHALL INCLUDE MENTAL HEALTH AND**
23 **SUBSTANCE ABUSE BENEFITS REQUIRED UNDER § 15–802 OF THIS TITLE AND §**
24 **19–703.1 OF THE HEALTH – GENERAL ARTICLE FOR EMPLOYERS THAT MEET**
25 **THE LARGE EMPLOYER DEFINITION UNDER § 15–802 OF THIS TITLE AND §**
26 **19–703.1 OF THE HEALTH – GENERAL ARTICLE.**

27 **[(e)] (F)** The Commission shall specify the deductibles and cost-sharing
28 associated with the benefits in the Standard Plan.

29 **[(f)] (G)** In establishing cost-sharing as part of the Standard Plan, the
30 Commission shall:

31 (1) include cost-sharing and other incentives to help prevent
32 consumers from seeking unnecessary services;

33 (2) balance the effect of cost-sharing in reducing premiums and in
34 affecting utilization of appropriate services; and

1 (3) limit the total cost-sharing that may be incurred by an individual
2 in a year.

3 **Article – Health – General**

4 19–703.1.

5 (a) (1) In this section the following terms have the meanings indicated.

6 (2) “Alcohol abuse” has the meaning stated in § 8–101 of this article.

7 (3) “Drug abuse” has the meaning stated in § 8–101 of this article.

8 (4) “Health benefit plan” has the meaning stated in § 15–1401 of the
9 Insurance Article.

10 (5) “Large employer” means an employer that has more than 50
11 employees and is not a small employer.

12 (6) “Managed care system” means a method that a carrier uses to
13 review and preauthorize a treatment plan that a health care practitioner develops for
14 a covered person using a variety of cost containment methods to control utilization,
15 quality, and claims.

16 (7) “Partial hospitalization” means the provision of medically directed
17 intensive or intermediate short-term treatment for mental illness, emotional
18 disorders, drug abuse or alcohol abuse for a period of less than 24 hours but more than
19 4 hours in a day for a member or subscriber in a licensed or certified facility or
20 program.

21 (8) “Small employer” [has the meaning stated in § 15–1201 of the
22 Insurance Article] **MEANS AN EMPLOYER THAT:**

23 **(I) EMPLOYED AN AVERAGE OF AT LEAST TWO, BUT NOT**
24 **MORE THAN 50 EMPLOYEES ON BUSINESS DAYS DURING THE PRECEDING**
25 **CALENDAR YEAR; AND**

26 **(II) EMPLOYS AT LEAST TWO EMPLOYEES ON THE FIRST DAY**
27 **OF THE PLAN YEAR.**

28 19–706.

29 **(KKKK) THE PROVISIONS OF § 15–137.1 OF THE INSURANCE ARTICLE**
30 **APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.**

31 19–732.

1 (a) **[A] EXCEPT AS OTHERWISE PROVIDED IN TITLE 15, SUBTITLE 10A**
2 **OF THE INSURANCE ARTICLE,** A party aggrieved by a final action of the
3 Commissioner under this subtitle has the right to a hearing and the right to appeal
4 from the action of the Commissioner under §§ 2–210 through 2–215 of the Insurance
5 Article.

6 SECTION 2. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall
7 apply, for group health benefit plans, to plan years that begin on or after July 1, 2011,
8 and for individual health benefit plans, for policy years that begin on or after July 1,
9 2011.

10 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
11 July 1, 2011.