SB0474/543925/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL 474
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 2, strike "**Reporting**" and substitute "**Notices, Reporting,**"; in line 3, after "of" insert "requiring that certain adverse decision and grievance decision notices include certain information in a certain manner;"; after line 8, insert:

"BY repealing and reenacting, without amendments,
Article - Insurance
Section 15-10A-02(a)
Annotated Code of Maryland
(2017 Replacement Volume and 2024 Supplement)";

and in line 11, after "Section" insert "15–10A–02(f) and (i) and".

AMENDMENT NO. 2

On page 1, after line 16, insert:

"15–10A–02.

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

(f) (1) For nonemergency cases, when a carrier renders an adverse decision, the carrier shall:

(i) inform the member, the member's representative, or the health care provider acting on behalf of the member of the adverse decision:

1. orally by telephone; or

2. with the affirmative consent of the member, the member's representative, or the health care provider acting on behalf of the member, by text, facsimile, e–mail, an online portal, or other expedited means; and

(ii) send, within 5 working days after the adverse decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

1. states in detail in clear, understandable language the specific factual bases for the carrier's decision and the reasoning used to determine that the health care service is not medically necessary and did not meet the carrier's criteria and standards used in conducting the utilization review;

2. provides the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision was based, and may not solely use:

A. generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary"; or

B. language directing the member to review the additional coverage criteria in the member's policy or plan documents;

3. **[**states the name,**]** **INCLUDES A UNIQUE IDENTIFIER FOR AND THE** business address**[**,**]** and business telephone number of:

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

B. if the carrier is not a health maintenance organization, the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process and the physician who is required to make all adverse decisions as required in § 15–10B–07(a) of this title;

4. gives written details of the carrier's internal grievance process and procedures under this subtitle; and

5. includes the following information:

A. that the member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

B. that a complaint may be filed without first filing a grievance if the member, the member's representative, 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;

C. the Commissioner's address, telephone number, and facsimile number;

D. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in both mediating and filing a grievance under the carrier's internal grievance process; and

E. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(2) The business telephone number included in the notice as required under paragraph (1)(ii)3 of this subsection must be a dedicated number for adverse decisions and may not be the general customer call number for the carrier.

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

(i) document the grievance decision in writing after the carrier has provided oral communication of the decision to the member, the member's representative, or the health care provider acting on behalf of the member; and

(ii) send, within 5 working days after the grievance decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

1. states in detail in clear, understandable language the specific factual bases for the carrier's decision and the reasoning used to determine that the health care service is not medically necessary and did not meet the carrier's criteria and standards used in conducting utilization review;

2. provides the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines used by the carrier, on which the grievance decision was based;

3. **[**states the name,**]** **INCLUDES A UNIQUE IDENTIFIER FOR AND THE** business address**[**.**]** and business telephone number of:

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

B. if the carrier is not a health maintenance organization, the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process and the designated employee or representative's title and clinical specialty; and

4. includes the following information:

A. that the member or the member's representative has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

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

C. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in filing a complaint with the Commissioner; and

D. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(2) The business telephone number included in the notice as required under paragraph (1)(ii)3 of this subsection must be a dedicated number for grievance decisions and may not be the general customer call number for the carrier.

(3) To satisfy the requirements of this subsection, a carrier may not use solely in the written notice sent under paragraph (1) of this subsection:

(i) generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary"; or

(ii) language directing the member to review the additional coverage criteria in the member's policy or plan documents.".

AMENDMENT NO. 3

On page 2, in line 30, strike "**AND**"; and in line 31, after "**INCREASE**" insert "**;** **AND**

(III) A DESCRIPTION OF THE CARRIER'S EFFORTS AND ACTIONS TAKEN TO DETERMINE THE REASON FOR THE INCREASE".