HOUSE BILL 848

J5 5lr2020
CF SB 474

By: **Delegates Pena–Melnyk, Bagnall, Cullison, Kerr, ~~and Rosenberg~~ Rosenberg, Bhandari, Chisholm, Guzzone, Hill, Hutchinson, S. Johnson, Kaiser, Kipke, Lopez, Martinez, Reilly, Szeliga, Taveras, White Holland, Woods, and Woorman**

Introduced and read first time: January 30, 2025
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted
Read second time: February 25, 2025

CHAPTER _____

AN ACT concerning

Health Insurance – Adverse Decisions – ~~Reporting~~ Notices, Reporting, and Examinations

FOR the purpose of requiring that certain adverse decision and grievance decision notices include certain information in a certain manner; requiring that certain information submitted to the Maryland Insurance Commissioner by carriers be aggregated by zip code; requiring certain carriers to provide certain information to the ~~Maryland Insurance~~ Commissioner on adverse decisions on types of services that have grown by ~~more than~~ certain percentages or more over certain periods of time; authorizing the Commissioner to use certain adverse decision information as the basis of a certain examination; and generally relating to health insurance and adverse decisions.

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

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–10A–02(f) and (i), 15–10A–06, and 15–10B–05(a)(4)

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

Annotated Code of Maryland
(2017 Replacement Volume and 2024 Supplement)

BY adding to
Article – Insurance
Section 15–10B–05(e)
Annotated Code of Maryland
(2017 Replacement Volume and 2024 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.

(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 AT THE TOP IN PROMINENT BOLD PRINT:

A. THAT THE NOTICE IS A DENIAL OF A REQUESTED HEALTH CARE SERVICE;

B. THAT THE MEMBER MAY FILE AN APPEAL;

C. THE PHONE NUMBER AND E–MAIL ADDRESS REQUIRED TO BE AVAILABLE UNDER § 15–10B–05(E) OF THIS TITLE; AND

D. THAT THE NOTICE INCLUDES ADDITIONAL INFORMATION ON HOW TO FILE AND RECEIVE ASSISTANCE FOR FILING A COMPLAINT;

[1.**] 2.** 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.**] 3.** 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.**] 4. [**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.**] 5.** gives written details of the carrier's internal grievance process and procedures under this subtitle; and

[5.**] 6.** 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**] (1)(II)4** 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 AT THE TOP IN PROMINENT BOLD PRINT:

A. THAT THE NOTICE IS A DENIAL OF A REQUESTED HEALTH CARE SERVICE;

B. THAT THE MEMBER MAY FILE A COMPLAINT WITH THE COMMISSIONER;

C. THE PHONE NUMBER AND E–MAIL ADDRESS REQUIRED TO BE AVAILABLE UNDER § 15–10B–05(E) OF THIS TITLE; AND

D. THAT THE NOTICE INCLUDES ADDITIONAL INFORMATION ON HOW TO FILE AND RECEIVE ASSISTANCE FOR AN APPEAL;

[1.**] 2.** 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.**]** **3.** 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.**]** **4.** **[**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.**]** **5.** 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**]** **(1)(II)4** 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.

15–10A–06.

(a) **(1)** On a quarterly basis, each carrier shall submit to the Commissioner, on the form the Commissioner requires, a report that describes **THE FOLLOWING INFORMATION AGGREGATED BY ZIP CODE AS REQUIRED BY THE COMMISSIONER**:

[(1)**]** **(I)** the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by the carrier;

[(2)**]** **(II)** the number of clean claims for reimbursement processed by the carrier;

[(3)**]** **(III)** the activities of the carrier under this subtitle, including:

[(i)**]** **1.** the outcome of each grievance filed with the carrier;

[(ii)**]** **2.** the number and outcomes of cases that were considered emergency cases under § 15–10A–02(b)(2)(i) of this subtitle;

[(iii)**]** **3.** the time within which the carrier made a grievance decision on each emergency case;

[(iv)**]** **4.** the time within which the carrier made a grievance decision on all other cases that were not considered emergency cases;

[(v)**]** **5.** the number of grievances filed with the carrier that resulted from an adverse decision involving length of stay for inpatient hospitalization as related to the medical procedure involved;

[(vi)**]** **6.** the number of adverse decisions issued by the carrier under § 15–10A–02(f) of this subtitle, whether the adverse decision involved a prior authorization or step therapy protocol, and the type of service at issue in the adverse decisions;

[(vii)**]** **7.** the number of adverse decisions overturned after a reconsideration request under § 15–10B–06 of this title; and

[(viii)**]** **8.** the number of requests made and granted under § 15–831(c)(1) and (2) of this title; and

[(4)**]** **(IV)** the number and outcome of all other cases that are not subject to activities of the carrier under this subtitle that resulted from an adverse decision involving the length of stay for inpatient hospitalization as related to the medical procedure involved.

(2) IF THE NUMBER OF ADVERSE DECISIONS ISSUED BY A CARRIER FOR A TYPE OF SERVICE HAS GROWN BY ~~MORE THAN~~ 10% OR MORE IN THE

IMMEDIATELY PRECEDING CALENDAR YEAR OR 25% OR MORE IN THE IMMEDIATELY PRECEDING 3 CALENDAR YEARS, THE CARRIER SHALL SUBMIT IN THE REPORT REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION:

(I) A DESCRIPTION OF ANY CHANGES IN MEDICAL MANAGEMENT CONTRIBUTING TO THE RISE IN ADVERSE DECISIONS FOR THE TYPE OF SERVICE; ~~AND~~

(II) ANY OTHER KNOWN REASONS FOR THE INCREASE; AND

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

(b) The Commissioner shall:

(1) compile an annual summary report based on the information provided:

(i) under subsection (a) of this section; and

(ii) by the Secretary under § 19–705.2(e) of the Health – General Article;

(2) report any violations or actions taken under § 15–10B–11 of this title; and

(3) provide copies of the summary report to the Governor and, subject to § 2–1257 of the State Government Article, to the General Assembly.

(C) THE COMMISSIONER MAY USE INFORMATION PROVIDED UNDER SUBSECTION (A) OF THIS SECTION AS THE BASIS FOR AN EXAMINATION UNDER TITLE 2, SUBTITLE 2 OF THIS ARTICLE.

15–10B–05.

(a) In conjunction with the application, the private review agent shall submit information that the Commissioner requires including:

(4) the procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and health care providers 7 days a week, 24 hours a day in this State **INCLUDING HAVING A DIRECT PHONE NUMBER AND MONITORED E–MAIL AS REQUIRED IN SUBSECTION (E) OF THIS SECTION**;

(E) (1) A PRIVATE REVIEW AGENT SHALL:

(I) HAVE AVAILABLE THE FOLLOWING DEDICATED TO UTILIZATION REVIEW:

1. A DIRECT TELEPHONE NUMBER THAT IS NOT THE GENERAL CUSTOMER CALL NUMBER; AND

2. A MONITORED E–MAIL ADDRESS; AND

(II) RESPOND TO VOICEMAILS OR E–MAILS WITHIN 2 BUSINESS DAYS AFTER RECEIPT OF THE VOICEMAIL OR E–MAIL.

(2) THE PHONE NUMBER AND E–MAIL ADDRESS SHALL BE PROMINENTLY DISPLAYED ON THE NOTICES REQUIRED UNDER § 15–10A–02(F) AND (I) OF THIS TITLE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2025.

Approved:

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Governor.

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Speaker of the House of Delegates.

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President of the Senate.