HOUSE BILL 1341

J5 5lr2202

By: **Delegates Woods, Bhandari, Kaiser, Kaufman, J. Long, Roberson, Roberts, Taylor, and White Holland**
Introduced and read first time: February 7, 2025
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Appeals and Adverse Decisions – Call Centers, Notification Requirements, and Required Survey

FOR the purpose of requiring health insurance carriers to operate a call center for appeals and adverse decisions, include certain information in a certain manner in the written notice of adverse decisions required to be sent to members, and conduct an annual survey on member experiences with the internal grievance process; and generally relating to health insurance appeals and adverse decisions.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–10A–02(e), (f), and (l) and 15–10A–06(a)(3)(viii) and (4)
Annotated Code of Maryland
(2017 Replacement Volume and 2024 Supplement)

BY adding to
Article – Insurance
Section 15–10A–02(l) and 15–10A–06(a)(5)
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.

(e) Each carrier shall:

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

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

(2) file any revision to the internal grievance process with the Commissioner and the Health Advocacy Unit at least 30 days before its intended use**; AND**

(3) OFFER A 24–HOUR CALL CENTER FOR MEMBERS WHO WISH TO APPEAL AN ADVERSE DECISION, OPERATED BY STAFF MEMBERS WHO RECEIVE ANNUAL TRAINING IN STATE INSURANCE LAWS AND REGULATIONS.

(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, 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 **IN 14 POINT BOLD FONT STATING THAT THE DECISION IS AN INSURANCE DENIAL AND** 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 **IN 14 POINT BOLD FONT;**

F. THE FOLLOWING STATEMENT IN 14 POINT BOLD FONT PLACED AT THE TOP OF THE NOTICE: "THIS IS AN INSURANCE DENIAL. FOR FREE HELP, IF YOU DON'T UNDERSTAND THIS DOCUMENT OR YOU WOULD LIKE HELP APPEALING THE DECISION, CONTACT THE MARYLAND INSURANCE ADMINISTRATION AT (INSERT THE NUMBER FOR THE ADMINISTRATION'S MEDICAL NECESSITY AND EMERGENCY APPEALS HOTLINE) OR THROUGH (INSERT THE ADDRESS FOR THE ADMINISTRATION'S WEBSITE).";

G. A QR CODE THAT LINKS TO A SHORT VIDEO PROVIDING GUIDANCE FOR MEMBERS ON NAVIGATING THE GRIEVANCE AND APPEALS PROCESS; AND

H. THE TELEPHONE NUMBER OF THE CALL CENTER REQUIRED UNDER SUBSECTION (E)(3) OF THIS SECTION.

(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.

(3) THE COMMISSIONER SHALL DEVELOP THE VIDEO REQUIRED UNDER PARAGRAPH (1)(II)5G OF THIS SUBSECTION.

(L) ON AN ANNUAL BASIS, EACH CARRIER SHALL:

(1) SURVEY MEMBERS ON THEIR EXPERIENCES WITH THE CARRIER'S INTERNAL GRIEVANCE PROCESS, INCLUDING EXPERIENCES WITH THE CALL CENTERS REQUIRED UNDER SUBSECTION (E)(3) OF THIS SECTION; AND

(2) SUBMIT THE RESULTS OF THE SURVEY TO THE COMMISSIONER.

[(l)**] (M)** (1) **[**Nothing in this**] THIS** subtitle **[**prohibits**] DOES NOT PROHIBIT** a carrier from delegating its internal grievance process to a private review agent that has a certificate issued under Subtitle 10B of this title and is acting on behalf of the carrier.

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

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

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

15–10A–06.

(a) On a quarterly basis, each carrier shall submit to the Commissioner, on the form the Commissioner requires, a report that describes:

(3) the activities of the carrier under this subtitle, including:

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

(4) 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**; AND**

(5) THE AVERAGE HOLD TIME AND TOTAL TIME FOR CALLS MADE TO THE CARRIER'S GRIEVANCE AND APPEAL CALL CENTERS, SEGREGATED BY EMERGENCY AND NONEMERGENCY CASES.

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