# Department of Legislative Services

Maryland General Assembly
2025 Session

## FISCAL AND POLICY NOTE
**Enrolled - Revised**

Senate Bill 474 (Senator Beidle)
Finance Health and Government Operations

**Health Insurance - Adverse Decisions - Notices, Reporting, and Examinations**

This bill expands the required contents of the written notice a carrier must provide to a member, a member's representative, and a health care provider acting on behalf of the member when the carrier renders a nonemergency adverse decision or grievance decision. The quarterly appeals and grievances report each carrier must submit to the Insurance Commissioner must include specified information aggregated by zip code as required by the Commissioner and specified information if the number of adverse decisions issued by a carrier for a type of service has grown by a specified amount. The Commissioner may use information provided in the quarterly appeals and grievances report as a basis for an examination of the carrier. The bill also requires a private review agent to (1) have a direct telephone number and monitored email address dedicated to utilization review; (2) respond to voicemails or emails within a certain period of time; and (3) post utilization review criteria and standards in a specified manner. **The bill's requirements to include specified unique identifiers in nonemergency adverse decision or grievance decision notices and that private review agents post utilization review criteria and standards in a specified manner take effect June 1, 2025.**

## Fiscal Summary

**State Effect:** Any impact on the Maryland Insurance Administration can be absorbed within existing budgeted resources. Revenues are not affected.

**Local Effect:** None.

**Small Business Effect:** None.

# Analysis

**Bill Summary:**

*Written Notice When a Carrier Renders an Adverse Decision*

Beginning June 1, 2025, the written notice a carrier must send when it renders a nonemergency adverse decision must include a unique identifier (rather than a name) for the medical director or associate medical director who made the adverse decision (for a health maintenance organization) or the designated employee or representative of the carrier who has responsibility for the internal grievance process and the physician required to make all adverse decisions (for all other types of carriers).

Beginning October 1, 2025, the written notice a carrier must send when it renders a nonemergency adverse decision must state at the top of the notice in prominent bold print that (1) the notice is a denial of a requested health care service; (2) the member may file an appeal; and (3) the notice includes additional information on how to file and receive assistance for filing a complaint. The notice must also include a specified telephone number and email address (as well as the unique identifier) for the medical director or associate medical director who made the adverse decision (for a health maintenance organization) or the designated employee or representative of the carrier who has responsibility for the internal grievance process and the physician required to make all adverse decisions (for all other types of carriers).

*Written Notice When a Carrier Renders a Grievance Decision*

Beginning June 1, 2025, the written notice a carrier must send when it renders a nonemergency grievance decision must include a unique identifier (rather than a name) for the medical director or associate medical director who made the grievance decision (for a health maintenance organization) or the designated employee or representative of the carrier who has responsibility for the internal grievance process (for all other types of carriers).

Beginning October 1, 2025, the written notice a carrier must send when it renders a nonemergency grievance decision must state at the top of the notice in prominent bold print that (1) the notice is a denial of a requested health care service; (2) the member may file a complaint with the Commissioner; and (3) the notice includes additional information on how to file and receive assistance for an appeal. The notice must also include a specified telephone number and email address (in addition to the unique identifier) for the medical director or associate medical director who made the grievance decision (for a health maintenance organization) or the designated employee or representative of the carrier who has responsibility for the internal grievance process (for all other types of carriers).

*Appeals and Grievances Report*

If the number of adverse decisions issued by a carrier for a type of service has grown by 10% or more in the immediately preceding calendar year or 25% or more in the immediately preceding three years, the carrier must include (1) a description of any changes in medical management contributing to the rise in adverse decisions for the type of service; (2) any other known reasons for the increase; and (3) a description of the carrier's efforts and actions taken to determine the reason for the increase.

*Private Review Agents*

Beginning June 1, 2025, a private review agent must post *on the member's and provider's pages* of its website the specific criteria and standards used in conducting utilization review and any subsequent revisions.

Beginning October 1, 2025, a private review agent must have a direct telephone number that is not the general customer call number and a monitored email address that are both dedicated to utilization review and prominently displayed on adverse decision and grievance notices sent by a carrier. A private review agent must respond to voicemails or emails within two business days, unless a shorter time period is otherwise required by law.

**Current Law:**

*Notice of Adverse Decisions and Grievances*

When a carrier renders an adverse decision or grievance decision, it must, among other actions, send within five working days a written notice to the member, the member's representative, and a health care provider acting on behalf of the member. The written notice must include specified information, including the factual bases for the carrier's decision, the name and business address of the individuals who made the decision, written details of the carrier's internal grievance process, and the right to file a complaint.

*Appeals and Grievances Report*

On a quarterly basis, each carrier must submit a report to the Commissioner that describes specified activities regarding appeals and grievances, including:

- the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by the carrier;
- the number of clean claims for reimbursement processed by the carrier;
- the outcome of each grievance filed with the carrier;

- the number and outcomes of cases that were considered emergency cases and subject to an expedited procedure;
- the time within which the carrier made a grievance decision on each case, including emergency and nonemergency cases;
- 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; and
- the number of adverse decisions issued by the carrier for a nonemergency case and the type of service at issue in the adverse decisions.

The report must also describe the number and outcome of all other cases that resulted from an adverse decision involving the length of stay for inpatient hospitalization as related to the medical procedure involved.

The Commissioner must compile an annual summary report based on the information provided by carriers (and information provided by the Secretary of Health regarding health maintenance organizations) and provide copies of the summary report to the Governor and the General Assembly.

*Private Review Agents*

A private review agent must submit specified information in conjunction with their application that the Commissioner requires, including the procedures and policies to ensure that a representative of the private review agent is reasonably available to patients and health care providers 7 days a week, 24 hours a day in this State.

## Additional Information

**Recent Prior Introductions:** Similar legislation has not been introduced within the last three years.

**Designated Cross File:** HB 848 (Delegate Pena-Melnyk, *et al.*) - Health and Government Operations.

**Information Source(s):** Maryland Insurance Administration; Department of Legislative Services

**Fiscal Note History:** First Reader - February 10, 2025
km/ljm Third Reader - March 18, 2025
Revised - Amendment(s) - March 18, 2025
Enrolled - April 28, 2025
Revised - Amendment(s) - April 28, 2025

---

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510