Chapter 165

(House Bill 1563)

AN ACT concerning

Emergency Room Services and Post–Acute Care – Coverage and Facility Studies

FOR the purpose of ~~prohibiting certain policies and contracts issued by insurers, nonprofit health service plans, and health maintenance organizations from denying insurance coverage for certain emergency room services under certain circumstances~~ authorizing the Maryland Insurance Commissioner to conduct an examination of certain decisions by carriers related to claims or authorization requests for services in, or related to services in, emergency departments; authorizing the Commissioner to have certain decisions independently reviewed under certain circumstances; requiring that a certain report required to be compiled by the ~~Maryland Insurance~~ Commissioner include data on certain adverse decisions and grievances; requiring the Maryland Health Care Commission, in conjunction with the Health Services Cost Review Commission, to conduct a study to quantify bed capacity in hospitals and post–acute settings in the State and make a recommendation on a certain collection and auditing process; requiring the Maryland Health Care Commission, in consultation with the Health Services Cost Review Commission, to study analyzing options to facilitate clinically appropriate transitions from acute to post–acute care settings in the State; and generally relating to emergency room services and post–acute care.

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–1A–14
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–10A–06
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

BY adding to
Article – Insurance
Section ~~15–504~~ 15–10B–21
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

~~BY repealing and reenacting, with amendments,~~
~~Article – Insurance~~
~~Section 15–10A–06~~

~~Annotated Code of Maryland~~
~~(2017 Replacement Volume and 2025 Supplement)~~

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

Article – Insurance

15–1A–14.

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

(2) "Emergency medical condition" means a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in a condition described in § 1867(e)(1) of the Social Security Act.

(3) (i) "Emergency services" means, with respect to an emergency medical condition:

1. a medical screening examination that is within the capability of the emergency department of a hospital or freestanding medical facility, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition;

2. any other examination or treatment within the capabilities of the staff and facilities available at the hospital or freestanding medical facility that is necessary to stabilize the patient, regardless of the department of the hospital in which the examination or treatment is furnished; or

3. except as provided in subparagraph (iii) of this paragraph, additional covered items and services furnished by a health care provider of emergency services that does not have a contractual relationship with the carrier after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in items 1 and 2 of this subparagraph are furnished.

(ii) "Emergency services" includes services described in subparagraph (i) of this paragraph that are provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis services.

(iii) Subject to § 14–205.2 of this article and § 19–710(p) of the Health – General Article, "emergency services" does not include items and services described in

subparagraph (i)3 of this paragraph if all of the conditions in 45 C.F.R. § 149.410(b) are met.

(b) If a carrier provides or covers any benefits for emergency services in an emergency department of a hospital or freestanding medical facility, the carrier:

(1) may not require prior authorization for the emergency services;

(2) shall provide coverage for the emergency services regardless of whether the health care provider providing the emergency services has a contractual relationship with the carrier to furnish emergency services;

(3) may not limit what constitutes an emergency medical condition solely on the basis of diagnosis codes; and

(4) may not impose any other term or condition on the coverage for emergency services, except for:

(i) the exclusion or coordination of benefits;

(ii) a waiting period; and

(iii) applicable cost–sharing.

(c) If a health care provider of emergency services does not have a contractual relationship with the carrier to provide emergency services, the carrier:

(1) may not impose any administrative requirement or limitation on coverage that would be more restrictive than administrative requirements or limitations imposed on coverage for emergency services furnished by a health care provider with a contractual relationship with the carrier;

(2) subject to § 14–205.2 of this article and § 19–710.1 of the Health – General Article, may not impose any cost–sharing amount greater than the amount imposed for emergency services furnished by a health care provider with a contractual relationship with the carrier;

(3) shall calculate and apply the cost–sharing amounts in accordance with the requirements of 45 C.F.R. § 149.110(b)(3)(iii) and (v); and

(4) except as provided in § 14–205.2 of this article and § 19–710.1 of the Health – General Article, shall reimburse the health care provider in accordance with the requirements of 45 C.F.R. § 149.110(b)(3)(iv).

~~**15–504.**~~

~~**AN INDIVIDUAL, GROUP, OR BLANKET POLICY OR CONTRACT ISSUED OR DELIVERED IN THE STATE BY AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION MAY NOT DENY A COVERED EMERGENCY ROOM SERVICE SOLELY ON THE BASIS THAT THE INSURED OR ENROLLEE DID NOT EXPERIENCE AN EMERGENCY MEDICAL CONDITION, AS DEFINED IN § 15–1A–14 OF THIS TITLE.**~~

~~SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:~~

~~**Article – Insurance**~~

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:

(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;

(ii) the number of clean claims for reimbursement processed by the carrier;

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

1. the outcome of each grievance filed with the carrier;

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

3. the time within which the carrier made a grievance decision on each emergency case;

4. the time within which the carrier made a grievance decision on all other cases that were not considered emergency cases;

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;

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, the type of service at issue in the adverse decisions,

and whether an artificial intelligence, algorithm, or other software tool was used in making the adverse decision;

7. the number of adverse decisions overturned after a reconsideration request under § 15–10B–06 of this title; and

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

(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 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;

(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) INCLUDE IN THE SUMMARY REPORT DATA ON ADVERSE DECISIONS AND GRIEVANCES RELATED TO POST–ACUTE SERVICES, INCLUDING ADVERSE DECISIONS AND GRIEVANCES RELATING TO ADMISSIONS TO SKILLED NURSING FACILITIES AND INPATIENT REHABILITATION FACILITIES;

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

[(3)**] (4)** 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–21.

(A) THE COMMISSIONER MAY CONDUCT AN EXAMINATION OF A CARRIER THAT HAS ISSUED A PATTERN OF ADVERSE DECISIONS OR GRIEVANCE DECISIONS FOR A CLAIM OR AUTHORIZATION REQUEST FOR SERVICES IN, OR RELATED TO SERVICES IN, AN EMERGENCY DEPARTMENT.

(B) A CARRIER EXAMINED UNDER SUBSECTION (A) OF THIS SECTION SHALL PRODUCE ALL DOCUMENTS RELATED TO AN ADVERSE DECISION OR GRIEVANCE DECISION DESCRIBED UNDER SUBSECTION (A) OF THIS SECTION, INCLUDING DOCUMENTS OR ELECTRONIC DOCUMENTS IN THE POSSESSION OF A PRIVATE REVIEW AGENT ACTING ON BEHALF OF THE CARRIER.

(C) (1) THE COMMISSIONER MAY HAVE AN ADVERSE DECISION OR GRIEVANCE DECISION DESCRIBED UNDER SUBSECTION (A) OF THIS SECTION REVIEWED BY AN INDEPENDENT REVIEW ORGANIZATION.

(2) THE COSTS OF A REVIEW CONDUCTED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE PAID BY THE CARRIER.

SECTION ~~3.~~ 2. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Care Commission, in conjunction with the Health Services Cost Review Commission and representatives from the post–acute care industry, shall:

(1) conduct a study to quantify bed capacity in post–acute care settings and in hospitals in the State; and

(2) make recommendations regarding a collection and auditing process by which hospital and post–acute beds will be reported to the Maryland Health Care Commission or the Health Services Cost Review Commission each year.

(b) The study required under subsection (a) of this section shall include:

(1) a count of the number of physical beds within each post–acute care facility in the State;

(2) the use of a standardized definition for each inpatient and outpatient bed type including Adult Medical, Adult Surgical, Adult Gynecological, Adult Addictions, Adult Obstetric, Adult Psychiatric, Adult Rehabilitation, Pediatric, Inpatient Observation,

Outpatient Observation, Observation Swing, and other types as determined jointly by the Commissions;

(3) a count of the number of physical beds, using the standardized definition, within each hospital in the State, by bed type;

(4) a count of the number of staffed beds, using the standardized definition, within each post–acute care facility in the State;

(5) a count of the number of staffed beds, using the standardized definition, within each hospital in the State, by bed type;

(6) a count of the number of licensed beds within each post–acute care facility in the State;

(7) a count of the number of licensed beds within each hospital in the State, by bed type;

(8) a count of the number of other types of beds as determined appropriate; and

(9) any other information necessary for the Maryland Health Care Commission and the Health Services Cost Review Commission to quantify bed capacity in the State.

(c) On or before January 1, 2027, the Maryland Health Care Commission, in conjunction with the Health Services Cost Review Commission, shall report the findings of the study conducted under this section and its recommendation regarding the process described in subsection (a)(2) of this section to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health Committee.

SECTION ~~4.~~ 3. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Care Commission, in consultation with the Health Services Cost Review Commission and representatives from the post–acute care industry, shall conduct a study analyzing options to facilitate clinically appropriate transitions from acute to post–acute care settings.

(b) The study conducted under subsection (a) of this section shall include:

(1) an analysis of the factors affecting efficiency of clinically appropriate transitions from acute to post–acute care settings;

(2) identification of potential solutions that can address the factors analyzed under item (1) of this subsection; and

(3) any other information necessary for the Maryland Health Care Commission or the Health Services Cost Review Commission to analyze options for clinically appropriate transitions from acute to post–acute care settings.

(c) On or before January 1, 2027, the Maryland Health Care Commission, in conjunction with the Health Services Cost Review Commission, shall report its findings and recommendations to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health Committee.

~~SECTION 5. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2027.~~

~~SECTION 6. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect January 1, 2027.~~

SECTION ~~7.~~ 4. AND BE IT FURTHER ENACTED, That~~, except as provided in Section 6 of this Act,~~ this Act shall take effect June 1, 2026.

Approved by the Governor, April 28, 2026.