

# HOUSE BILL 1563

J1, J3, J5

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By: **The Speaker and Delegate Bhandari**

Introduced and read first time: February 13, 2026

Assigned to: Health

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## A BILL ENTITLED

1 AN ACT concerning

2 **Emergency Room Services and Post-Acute Care – Coverage and Facility Studies**

3 FOR the purpose of prohibiting certain policies and contracts issued by insurers, nonprofit  
4 health service plans, and health maintenance organizations from denying insurance  
5 coverage for certain emergency room services under certain circumstances; requiring  
6 that a certain report required to be compiled by the Maryland Insurance  
7 Commissioner include data on certain adverse decisions and grievances; requiring  
8 the Maryland Health Care Commission, in conjunction with the Health Services Cost  
9 Review Commission, to conduct a study to quantify bed capacity in hospitals and  
10 post-acute settings in the State and make a recommendation on a certain collection  
11 and auditing process; requiring the Maryland Health Care Commission, in  
12 consultation with the Health Services Cost Review Commission, to study analyzing  
13 options to facilitate clinically appropriate transitions from acute to post-acute care  
14 settings in the State; and generally relating to emergency room services and  
15 post-acute care.

16 BY repealing and reenacting, without amendments,  
17 Article – Insurance  
18 Section 15-1A-14  
19 Annotated Code of Maryland  
20 (2017 Replacement Volume and 2025 Supplement)

21 BY adding to  
22 Article – Insurance  
23 Section 15-504  
24 Annotated Code of Maryland  
25 (2017 Replacement Volume and 2025 Supplement)

26 BY repealing and reenacting, with amendments,  
27 Article – Insurance  
28 Section 15-10A-06

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EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 Annotated Code of Maryland  
2 (2017 Replacement Volume and 2025 Supplement)

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

5 **Article – Insurance**

6 15–1A–14.

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

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

14 (3) (i) “Emergency services” means, with respect to an emergency  
15 medical condition:

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

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

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

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

33 (iii) Subject to § 14–205.2 of this article and § 19–710(p) of the Health  
34 – General Article, “emergency services” does not include items and services described in  
35 subparagraph (i)3 of this paragraph if all of the conditions in 45 C.F.R. § 149.410(b) are  
36 met.

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

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

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

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

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

11 (i) the exclusion or coordination of benefits;

12 (ii) a waiting period; and

13 (iii) applicable cost-sharing.

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

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

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

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

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

29 **15-504.**

30 **AN INDIVIDUAL, GROUP, OR BLANKET POLICY OR CONTRACT ISSUED OR**  
31 **DELIVERED IN THE STATE BY AN INSURER, A NONPROFIT HEALTH SERVICE PLAN,**  
32 **OR A HEALTH MAINTENANCE ORGANIZATION MAY NOT DENY A COVERED**

1 EMERGENCY ROOM SERVICE SOLELY ON THE BASIS THAT THE INSURED OR  
2 ENROLLEE DID NOT EXPERIENCE AN EMERGENCY MEDICAL CONDITION, AS DEFINED  
3 IN § 15-1A-14 OF THIS TITLE.

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

6 **Article – Insurance**

7 15-10A-06.

8 (a) (1) On a quarterly basis, each carrier shall submit to the Commissioner, on  
9 the form the Commissioner requires, a report that describes the following information  
10 aggregated by zip code as required by the Commissioner:

11 (i) the number of members entitled to health care benefits under a  
12 policy, plan, or certificate issued or delivered in the State by the carrier;

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

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

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

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

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

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

23 5. the number of grievances filed with the carrier that  
24 resulted from an adverse decision involving length of stay for inpatient hospitalization as  
25 related to the medical procedure involved;

26 6. the number of adverse decisions issued by the carrier  
27 under § 15-10A-02(f) of this subtitle, whether the adverse decision involved a prior  
28 authorization or step therapy protocol, the type of service at issue in the adverse decisions,  
29 and whether an artificial intelligence, algorithm, or other software tool was used in making  
30 the adverse decision;

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

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

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

6                   (2)   If the number of adverse decisions issued by a carrier for a type of  
7 service has grown by 10% or more in the immediately preceding calendar year or 25% or  
8 more in the immediately preceding 3 calendar years, the carrier shall submit in the report  
9 required under paragraph (1) of this subsection:

10                  (i)   a description of any changes in medical management  
11 contributing to the rise in adverse decisions for the type of service;

12                  (ii)   any other known reasons for the increase; and

13                  (iii)  a description of the carrier's efforts and actions taken to  
14 determine the reason for the increase.

15           (b)   The Commissioner shall:

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

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

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

20                   **(2)   INCLUDE IN THE SUMMARY REPORT DATA ON ADVERSE DECISIONS**  
21 **AND GRIEVANCES RELATED TO POST-ACUTE SERVICES, INCLUDING ADVERSE**  
22 **DECISIONS AND GRIEVANCES RELATING TO ADMISSIONS TO SKILLED NURSING**  
23 **FACILITIES AND INPATIENT REHABILITATION FACILITIES;**

24                   **[(2)] (3)**     report any violations or actions taken under § 15–10B–11 of this  
25 title; and

26                   **[(3)] (4)**     provide copies of the summary report to the Governor and,  
27 subject to § 2–1257 of the State Government Article, to the General Assembly.

28           (c)   The Commissioner may use information provided under subsection (a) of this  
29 section as the basis for an examination under Title 2, Subtitle 2 of this article.

30           SECTION 3. AND BE IT FURTHER ENACTED, That:

1 (a) The Maryland Health Care Commission, in conjunction with the Health  
2 Services Cost Review Commission, shall:

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

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

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

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

11 (2) the use of a standardized definition for each inpatient and outpatient  
12 bed type including Adult Medical, Adult Surgical, Adult Gynecological, Adult Addictions,  
13 Adult Obstetric, Adult Psychiatric, Adult Rehabilitation, Pediatric, Inpatient Observation,  
14 Outpatient Observation, Observation Swing, and other types as determined jointly by the  
15 Commissions;

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

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

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

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

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

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

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

31 (c) On or before January 1, 2027, the Maryland Health Care Commission, in  
32 conjunction with the Health Services Cost Review Commission, shall report the findings of  
33 the study conducted under this section and its recommendation regarding the process  
34 described in subsection (a)(2) of this section to the Governor and, in accordance with §

1 2–1257 of the State Government Article, the Senate Finance Committee and the House  
2 Health Committee.

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

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

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

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

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

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

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

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

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

24 SECTION 7. AND BE IT FURTHER ENACTED, That, except as provided in Section  
25 6 of this Act, this Act shall take effect June 1, 2026.