CHAPTER 173

(Senate Bill 856)

AN ACT concerning

Health Insurance – Appeals and Grievances Procedures – Modifications

FOR the purpose of establishing, for a retrospective denial, a certain minimum time period for a member or a health care provider on behalf of a member to file a grievance related to a carrier's adverse decision; extending the time period for a member or a health care provider on behalf of a member to file a complaint with the Insurance Commissioner for review of a carrier's grievance decision; altering certain notice requirements; requiring carriers to report certain information to the Insurance Commissioner on a quarterly basis; providing for the application of certain portions of this Act; and generally relating to modifications of the procedures for appeals and grievances of adverse decisions and grievance decisions related to health insurance claims.

BY repealing and reenacting, with amendments,

Article – Insurance

Section 15–10A–02(b), (f), and (i), 15–10A–03(a), and 15–10A–06(a)

Annotated Code of Maryland

(1997 Volume and 2000 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.

(b) (1) An internal grievance process shall meet the same requirements established under Subtitle 10B of this title.

(2) In addition to the requirements of Subtitle 10B of this title, an internal grievance process established by a carrier under this section shall:

(i) include an expedited procedure for use in an emergency case for purposes of rendering a grievance decision within 24 hours of the date a grievance is filed with the carrier;

(ii) provide that a carrier render a final decision in writing on a grievance within 30 working days after the date on which the grievance is filed unless:

1. the grievance involves an emergency case under item (i) of this paragraph;