HOUSE BILL 1150

C3 6lr2815
CF SB 887

By: **Delegates McMillan, Angel, Cullison, Hayes, Kipke, Miele, Morgan, Oaks, Pena–Melnyk, Saab, and West**
Introduced and read first time: February 11, 2016
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Consumer Health Claim Filing Fairness Act

FOR the purpose of requiring a certain health benefit plan to include provisions that permit enrollees a certain minimum period of time to submit a claim for a service, provide for the suspension of the minimum period of time under certain circumstances, and provide that failure to submit a claim within the minimum period of time does not invalidate or reduce the amount of the claim under certain circumstances; creating an exception to a provision of law that requires certain proof of loss to be furnished to an insurer in case of claim for loss within a certain period of time; defining certain terms; providing for the application of this Act; providing for a delayed effective date; and generally relating to the time period for submitting a claim under health insurance.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 12–102 and 15–213
Annotated Code of Maryland
(2011 Replacement Volume and 2015 Supplement)

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

Article – Insurance

12–102.

(a) Except as provided in subsection (b)(1) of this section, an insurance contract or annuity contract shall contain the standard provisions required under this article.

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

(b) (1) The Commissioner may waive the required use of a provision in an insurance policy or contract form if the Commissioner:

(i) finds that the provision is unnecessary to protect the insured or is inconsistent with the purposes of the policy; and

(ii) approves the policy.

(2) A required standard provision may not be waived by agreement between an insurer and another person.

(C) (1) (I) IN THIS SUBSECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(II) "CARRIER" MEANS:

1. AN INSURER AUTHORIZED TO SELL HEALTH INSURANCE;

2. A NONPROFIT HEALTH SERVICE PLAN;

3. A HEALTH MAINTENANCE ORGANIZATION;

4. A DENTAL PLAN ORGANIZATION; OR

5. ANY OTHER ENTITY PROVIDING A PLAN OF HEALTH INSURANCE, HEALTH BENEFITS, OR HEALTH SERVICES AUTHORIZED UNDER THIS ARTICLE OR THE AFFORDABLE CARE ACT.

(III) "ENROLLEE" MEANS AN INDIVIDUAL ENTITLED TO BENEFITS FROM A CARRIER'S HEALTH BENEFIT PLAN.

(IV) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 15–140 OF THIS ARTICLE.

(2) EACH HEALTH BENEFIT PLAN ISSUED BY A CARRIER SHALL INCLUDE PROVISIONS THAT:

(I) PERMIT ENROLLEES A MINIMUM OF 1 YEAR AFTER THE DATE OF SERVICE TO SUBMIT A CLAIM FOR THE SERVICE;

(II) PROVIDE THAT:

1. AN ENROLLEE'S LEGAL INCAPACITY SHALL SUSPEND THE TIME TO SUBMIT A CLAIM; AND

2. THE SUSPENSION PERIOD ENDS WHEN LEGAL CAPACITY IS REGAINED; AND

(III) PROVIDE THAT THE FAILURE TO SUBMIT A CLAIM WITHIN 1 YEAR AFTER THE DATE OF SERVICE DOES NOT INVALIDATE OR REDUCE THE AMOUNT OF THE CLAIM IF:

1. THE DELAY WAS NOT UNREASONABLE; AND

2. THE CLAIM IS SUBMITTED WITHIN 2 YEARS AFTER THE DATE OF SERVICE.

[(c)**] (D)** The Commissioner may approve a substitute provision in an insurance policy or annuity contract if the provision is not less favorable than the required provision to the insured, annuitant, or beneficiary.

[(d)**] (E)** Instead of a provision required by this article, a foreign insurer or alien insurer may use a substantially similar provision required by the law of the foreign insurer's or alien insurer's domicile if the substantially similar provision does not conflict with the law of this State.

[(e)**] (F)** A policy or contract may not contain a provision that is inconsistent with a standard provision used or required to be used.

15–213.

[Each**] EXCEPT AS PROVIDED IN § 12–102(C) OF THIS ARTICLE, EACH** policy of health insurance shall contain the following provision:

"Proofs of loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required."

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all health benefit plans issued, delivered, or renewed in the State on or after January 1, 2017.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2017.