Chapter 3

(Senate Bill 183)

AN ACT concerning

Health Insurance – Conformity with Federal Law

FOR the purpose of altering the circumstances under which a person has the right to a hearing and the right to an appeal from an action of the Maryland Insurance Commissioner; requiring the Commissioner to file certain documents in a court in which a certain appeal is pending; providing that certain provisions of federal law apply to certain health insurance coverage issued or delivered by certain insurers, nonprofit health service plans, and health maintenance organizations; authorizing the Commissioner to enforce certain provisions of law; altering the requirement for certain insurers, nonprofit health service plans, and health maintenance organizations to send a certain notice when a child who is covered under a certain insurance policy or contract reaches a certain age; requiring certain health insurance coverage issued or delivered by certain insurers, nonprofit health service plans, and health maintenance organizations to comply with certain loss ratio requirements; authorizing a member's representative to file a certain grievance, complaint, or appeal; altering the circumstances under which a certain complaint may be filed with the Commissioner; altering requirements for certain filings, timeframes, notices, and evidence of coverage information relating to appeals and grievances; requiring the Commissioner to seek advice from certain independent review organizations or certain medical advisors on certain complaints; altering the information that a certain independent review organization must submit to the Commissioner; requiring certain carriers to provide certain notices to certain members in a manner described in the Patient Protection and Affordable Care Act; altering the calculation of a minimum participation requirement in the small group health insurance market; requiring the Maryland Health Care Commission to include certain mental health and substance abuse benefits under the Standard Health Benefit Plan; making certain provisions of this Act applicable to health maintenance organizations; altering certain definitions; defining certain terms; making conforming and technical changes; providing for the application of this Act; and generally relating to conformity with federal law relating to health insurance and mental health benefits.

BY repealing and reenacting, without amendments,
Article – Insurance
Section 1–101(a) and (b)
Annotated Code of Maryland
(2003 Replacement Volume and 2010 Supplement)

BY adding to
Article – Insurance
Section 1–101(b–1)
Annotated Code of Maryland
(2003 Replacement Volume and 2010 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 2–210(a) and 2–215(a), (b), (d), and (g)
Annotated Code of Maryland
(2003 Replacement Volume and 2010 Supplement)

BY adding to
Article – Insurance
Section 15–137.1, 15–10A–01(m), 15–10A–04(e), 15–10A–10, and 15–10D–05
Annotated Code of Maryland
(2006 Replacement Volume and 2010 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–416, 15–605(c), 15–802(a), 15–10A–01(f) and (m), 15–10A–02, 15–10A–03, 15–10A–04(a), 15–10A–05, 15–10D–01, 15–10D–02, 15–1206(c), and 15–1207
Annotated Code of Maryland
(2006 Replacement Volume and 2010 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–10A–01(a) and (l)
Annotated Code of Maryland
(2006 Replacement Volume and 2010 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–703.1(a) and 19–732(a)
Annotated Code of Maryland
(2009 Replacement Volume and 2010 Supplement)

BY adding to
Article – Health –General
Section 19–706(kkkk)
Annotated Code of Maryland
(2009 Replacement Volume and 2010 Supplement)

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

Article – Insurance

1–101.

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

(b) "Administration" means the Maryland Insurance Administration.

(B–1) "AFFORDABLE CARE ACT" MEANS THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010, AND ANY REGULATIONS ADOPTED OR GUIDANCE ISSUED UNDER THE ACTS.

2–210.

(a) (1) The Commissioner may hold hearings that the Commissioner considers necessary for any purpose under this article.

(2) The Commissioner shall hold a hearing:

(i) if required by any provision of this article; or

(ii) **EXCEPT AS OTHERWISE PROVIDED IN THIS ARTICLE,** on written demand by a person aggrieved by any act of, threatened act of, or failure to act by the Commissioner or by any report, regulation, or order of the Commissioner, except an order to hold a hearing or an order resulting from a hearing.

2–215.

(a) An appeal under this subtitle may be taken only from:

(1) an order resulting from a hearing; **[**or**]**

(2) a refusal by the Commissioner to grant a hearing**; OR**

(3) A DECISION ISSUED UNDER ~~TITLE 15, SUBTITLE 10A~~ § 15–10A–04 OF THIS ARTICLE.

(b) An appeal under this subtitle may be taken by:

(1) a party to the hearing; **[**or**]**

(2) an aggrieved person whose financial interests are directly affected by the order resulting from a hearing or refusal to grant a hearing**; OR**

(3) A PARTY TO THE DECISION ISSUED UNDER § 15–10A–04 OF THIS ARTICLE.

(d) To take an appeal, a person shall file a petition for judicial review with the appropriate circuit court within 30 days after:

(1) the order resulting from the hearing was served on the persons entitled to receive it;

(2) the order of the Commissioner denying rehearing or reargument was served on the persons entitled to receive it; **[**or**]**

(3) the refusal of the Commissioner to grant a hearing**; OR**

(4) THE DECISION ISSUED UNDER § 15–10A–04 OF THIS ARTICLE WAS SERVED ON THE PERSONS ENTITLED TO RECEIVE IT.

(g) (1) In an appeal of an order resulting from a hearing, after receiving a copy of the petition for judicial review and within the time specified in the Maryland Rules, the Commissioner shall file in the court in which the appeal is pending:

(i) a copy of the order of the Commissioner from which the appeal is taken;

(ii) a complete transcript, certified by the Commissioner, of the record on which the order was issued; and

(iii) all exhibits and documentary evidence introduced at the hearing.

(2) In an appeal of a refusal by the Commissioner to grant a hearing, within the time specified in the Maryland Rules, the Commissioner shall file in the court in which the appeal is pending certified copies of all documents on file with the Commissioner that directly relate to the matter on appeal.

(3) IN AN APPEAL OF A DECISION ISSUED UNDER § 15–10A–04 OF THIS ARTICLE, AFTER RECEIVING A COPY OF THE PETITION FOR JUDICIAL REVIEW AND WITHIN THE TIME SPECIFIED IN THE MARYLAND RULES, THE COMMISSIONER SHALL FILE IN THE COURT IN WHICH THE APPEAL IS PENDING:

(I) A COPY OF THE DECISION OF THE COMMISSIONER FROM WHICH THE APPEAL IS TAKEN;

(II) A COPY OF THE REPORT OF THE INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT; AND

(III) ALL DOCUMENTARY EVIDENCE PROVIDED TO THE COMMISSIONER AND THE INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT THAT DIRECTLY RELATES TO THE MATTER ON APPEAL.

15–137.1.

(A) NOTWITHSTANDING ANY OTHER PROVISIONS OF LAW, THE FOLLOWING PROVISIONS OF TITLE I, SUBTITLES A AND C OF THE ~~FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY §§ 10101 AND 10103 OF THAT ACT AND THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 AND ANY OTHER APPLICABLE REGULATIONS OR OTHER FEDERAL REQUIREMENTS, APPLY TO ALL INSURERS, NONPROFIT HEALTH SERVICE PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS THAT DELIVER OR ISSUE FOR DELIVERY INDIVIDUAL, GROUP, OR BLANKET HEALTH INSURANCE POLICIES OR CONTRACTS IN THE STATE~~ AFFORDABLE CARE ACT APPLY TO INDIVIDUAL HEALTH INSURANCE COVERAGE AND HEALTH INSURANCE COVERAGE OFFERED IN THE SMALL GROUP AND LARGE GROUP MARKETS, AS THOSE TERMS ARE DEFINED IN THE FEDERAL PUBLIC HEALTH SERVICE ACT, ISSUED OR DELIVERED IN THE STATE BY AN AUTHORIZED INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION:

(1) COVERAGE OF CHILDREN UP TO THE AGE OF 26 YEARS;

(2) PREEXISTING CONDITION EXCLUSIONS;

(3) POLICY RESCISSIONS;

(4) BONA FIDE WELLNESS PROGRAMS;

(5) LIFETIME LIMITS;

(6) ANNUAL LIMITS FOR ESSENTIAL BENEFITS;

(7) WAITING PERIODS;

(8) DESIGNATION OF PRIMARY CARE PROVIDERS;

(9) ACCESS TO OBSTETRICAL AND GYNECOLOGICAL SERVICES;

(10) EMERGENCY SERVICES;

(11) SUMMARY OF BENEFITS AND COVERAGE EXPLANATION;

(12) MINIMUM LOSS RATIO REQUIREMENTS AND PREMIUM REBATES; AND

(13) DISCLOSURE OF INFORMATION.

(B) THE PROVISIONS OF SUBSECTION (A) OF THIS SECTION DO NOT APPLY TO COVERAGE FOR EXCEPTED BENEFITS, AS DEFINED IN 45 C.F.R. § 146.145(C).

(C) THE COMMISSIONER MAY ENFORCE THIS SECTION UNDER ANY APPLICABLE PROVISIONS OF THIS ARTICLE.

15–416.

(a) This section applies to insurers, nonprofit health service plans, and health maintenance organizations that deliver or issue for delivery in the State individual, group, or blanket health insurance policies and contracts.

(b) At least 60 days before a child who is covered under a parent's individual, group, or blanket health insurance policy or contract **[**turns 18 years of age**]** **REACHES THE LIMITING AGE UNDER THE POLICY OR CONTRACT**, an entity subject to this section shall:

(1) notify the parent of criteria under which a child may remain eligible for coverage as a dependent under the policy or contract; and

(2) provide information regarding:

(i) any other policies that may be available to the child from the entity; and

(ii) the availability of additional information from the Administration regarding individual policies in the State.

(c) The Commissioner shall establish and publish by bulletin the notice to be given under this section.

15–605.

(c) (1) **[**For a health benefit plan that is issued under Subtitle 12 of this title, the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than 75%.

(2) (i) Subject to subparagraph (ii) of this paragraph, for a health benefit plan that is issued to individuals the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than 60%.

(ii) Subparagraph (i) of this paragraph does not apply to an insurance product that:

1. is listed under § 15–1201(f)(3) of this title; or

2. is nonrenewable and has a policy term of no more than 6 months.

(iii) The Commissioner may establish a loss ratio for each insurance product described in subparagraph (ii)1 and 2 of this paragraph.**]**

~~**(I) AN AUTHORIZED INSURER, NONPROFIT HEALTH SERVICE PLAN, AND HEALTH MAINTENANCE ORGANIZATION REQUIRED TO SUBMIT AN ANNUAL REPORT UNDER SUBSECTION (A)(1) OF THIS SECTION**~~

(I) INDIVIDUAL HEALTH INSURANCE COVERAGE AND HEALTH INSURANCE COVERAGE OFFERED IN THE SMALL GROUP AND LARGE GROUP MARKETS, AS THOSE TERMS ARE DEFINED IN THE FEDERAL PUBLIC HEALTH SERVICE ACT, ISSUED OR DELIVERED IN THE STATE BY AN AUTHORIZED INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL COMPLY WITH THE LOSS RATIO REQUIREMENTS OF SECTIONS 1001(5) AND 10101(F) OF THE AFFORDABLE CARE ACT, WHICH AMEND SECTION 2718 OF THE PUBLIC HEALTH SERVICE ACT.

(II) THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH DO NOT APPLY TO COVERAGE FOR EXCEPTED BENEFITS, AS DEFINED IN 45 C.F.R. § 146.145(C).

~~**(II)**~~ **(III) THE COMMISSIONER MAY REQUIRE AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION TO FILE NEW RATES IF THE LOSS RATIO REPORTED IN THE MANNER REQUIRED UNDER 45 C.F.R. § 158 IS LESS THAN THAT REQUIRED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.**

[(3)**] (2)** The authority of the Commissioner under **[**paragraphs (1) and (2)**]** **PARAGRAPH (1)** of this subsection to require an insurer, nonprofit health service plan, or health maintenance organization to file new rates based on loss ratio:

(i) is in addition to any other authority of the Commissioner under this article to require that rates not be excessive, inadequate, or unfairly discriminatory; and

(ii) does not limit any existing authority of the Commissioner to determine whether a rate is excessive.

[(4)**] (3)** (i) In determining whether to require an insurer to file new rates under this subsection, the Commissioner may consider the amount of health insurance premiums earned in the State on individual policies in proportion to the total health insurance premiums earned in the State for the insurer.

(ii) The insurer shall provide to the Commissioner the information necessary to determine the proportion of individual health insurance premiums to total health insurance premiums as provided under this paragraph.

[(5)**] (4)** The Secretary of Health and Mental Hygiene, in consultation with the Commissioner and in accordance with their memorandum of understanding, may adjust capitation payments for a managed care organization or for the Maryland Medical Assistance Program of a managed care organization that is a certified health maintenance organization**[**:

(i) if the loss ratio is less than 80% during calendar year 1997; and

(ii) during each subsequent calendar year**]** if the loss ratio is less than 85%.

[(6)**] (5)** A loss ratio reported under paragraph **[**(5)**] (4)** of this subsection shall be calculated separately and may not be part of another loss ratio reported under this section.

[(7)**] (6)** Any rebate received by a managed care organization may not be considered part of the loss ratio of the managed care organization.

[(8)**] (7)** If the Secretary of Health and Mental Hygiene adjusts capitation payments for a managed care organization or a certified health maintenance organization under paragraph **[**(5)**] (4)** of this subsection, the managed care organization or certified health maintenance organization may:

(i) appeal the decision of the Secretary to the Board of Review established under Title 2, Subtitle 2 of the Health – General Article; and

(ii) take any further appeal allowed by the Administrative Procedure Act under Title 10, Subtitle 2 of the State Government Article.

15–802.

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

(2) "Alcohol abuse" has the meaning stated in § 8–101 of the Health – General Article.

(3) "Drug abuse" has the meaning stated in § 8–101 of the Health – General Article.

(4) "Health benefit plan" has the meaning stated in § 15–1401 of this title.

(5) "Large employer" means an employer that has more than 50 employees and is not a small employer.

(6) "Managed care system" means a system of cost containment methods that a carrier uses to review and preauthorize a treatment plan developed by a health care provider for a covered individual in order to control utilization, quality, and claims.

(7) "Partial hospitalization" means the provision of medically directed intensive or intermediate short–term treatment:

(i) to an insured, subscriber, or member;

(ii) in a licensed or certified facility or program;

(iii) for mental illness, emotional disorders, drug abuse, or alcohol abuse; and

(iv) for a period of less than 24 hours but more than 4 hours in a day.

(8) "Small employer" **[**has the meaning stated in § 15–1201 of this title**]** **MEANS AN EMPLOYER THAT:**

(I) EMPLOYED AN AVERAGE OF AT LEAST TWO, BUT NOT MORE THAN 50 EMPLOYEES ON BUSINESS DAYS DURING THE PRECEDING CALENDAR YEAR; AND

(II) EMPLOYS AT LEAST TWO EMPLOYEES ON THE FIRST DAY OF THE PLAN YEAR.

15–10A–01.

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

(f) "Grievance" means a protest filed by a member**, A MEMBER'S REPRESENTATIVE,** or a health care provider on behalf of a member with a carrier through the carrier's internal grievance process regarding an adverse decision concerning the member.

(l) (1) "Member" means a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by a carrier.

(2) "Member" includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) "Member" does not include a Medicaid recipient.

(M) "MEMBER'S REPRESENTATIVE" MEANS AN INDIVIDUAL WHO HAS BEEN AUTHORIZED BY THE MEMBER TO FILE A GRIEVANCE OR A COMPLAINT ON THE MEMBER'S BEHALF.

[(m)**] (N)** "Private review agent" has the meaning stated in § 15–10B–01 of this title.

15–10A–02.

(a) Each carrier shall establish an internal grievance process for its members.

(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;

2. the member**, THE MEMBER'S REPRESENTATIVE,** or a health care provider filing a grievance on behalf of a member agrees in writing to an extension for a period of no longer than 30 working days; or

3. the grievance involves a retrospective denial under item (iv) of this paragraph;

(iii) allow a grievance to be filed on behalf of a member by a health care provider **OR THE MEMBER'S REPRESENTATIVE**;

(iv) provide that a carrier render a final decision in writing on a grievance within 45 working days after the date on which the grievance is filed when the grievance involves a retrospective denial; and

(v) for a retrospective denial, allow a member**, THE MEMBER'S REPRESENTATIVE,** or a health care provider on behalf of a member to file a grievance for at least 180 days after the member receives an adverse decision.

(3) For purposes of using the expedited procedure for an emergency case that a carrier is required to include under paragraph (2)(i) of this subsection, the Commissioner shall define by regulation the standards required for a grievance to be considered an emergency case.

(c) Except as provided in subsection (d) of this section, the carrier's internal grievance process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) (1) (i) A member**, THE MEMBER'S REPRESENTATIVE,** or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if**:**

1. THE CARRIER WAIVES THE REQUIREMENT THAT THE CARRIER'S INTERNAL GRIEVANCE PROCESS BE EXHAUSTED BEFORE FILING A COMPLAINT WITH THE COMMISSIONER;

2. THE CARRIER HAS FAILED TO COMPLY WITH ANY OF THE REQUIREMENTS OF THE INTERNAL GRIEVANCE PROCESS AS DESCRIBED IN THIS SECTION; OR

3. the member**, THE MEMBER'S REPRESENTATIVE,** or the health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

(ii) The Commissioner shall define by regulation the standards that the Commissioner shall use to decide what demonstrates a compelling reason under subparagraph (i) of this paragraph.

(2) Subject to subsections (b)(2)(ii) and (h) of this section, a member**, A MEMBER'S REPRESENTATIVE,** or a health care provider may file a complaint with the Commissioner if the member**, THE MEMBER'S REPRESENTATIVE,** or the health care provider does not receive a grievance decision from the carrier on or before the 30th working day on which the grievance is filed.

(3) Whenever the Commissioner receives a complaint under paragraph (1) or (2) of this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(e) Each carrier shall:

(1) file for review with the Commissioner and submit to the Health Advocacy Unit a copy of its internal grievance process established under this subtitle; and

(2) **[**update the initial filing annually to reflect any changes made**]** **FILE ANY REVISION TO THE INTERNAL GRIEVANCE PROCESS WITH THE COMMISSIONER AND THE HEALTH ADVOCACY UNIT AT LEAST 30 DAYS BEFORE ITS INTENDED USE**.

(f) For nonemergency cases, when a carrier renders an adverse decision, the carrier shall:

(1) document the adverse decision in writing after the carrier has provided oral communication of the decision to the member**, THE MEMBER'S REPRESENTATIVE,** or the health care provider acting on behalf of the member; and

(2) send, within 5 working days after the adverse decision has been made, a written notice to the member**, THE MEMBER'S REPRESENTATIVE,** and a health care provider acting on behalf of the member that:

(i) states in detail in clear, understandable language the specific factual bases for the carrier's decision;

(ii) references the specific criteria and standards, including interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";

(iii) states the name, business address, and business telephone number of:

1. the medical director or associate medical director, as appropriate, who made the decision if the carrier is a health maintenance organization; or

2. the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization;

(iv) gives written details of the carrier's internal grievance process and procedures under this subtitle; and

(v) includes the following information:

1. that the member**, THE MEMBER'S REPRESENTATIVE,** or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within **[**30 working days**] 4 MONTHS** after receipt of a carrier's grievance decision;

2. that a complaint may be filed without first filing a grievance if the member**, THE MEMBER'S REPRESENTATIVE,** or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner;

3. the Commissioner's address, telephone number, and facsimile number;

4. a statement that the Health Advocacy Unit is available to assist the member **OR THE MEMBER'S REPRESENTATIVE** in both mediating and filing a grievance under the carrier's internal grievance process; and

5. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(g) If within 5 working days after a member**, THE MEMBER'S REPRESENTATIVE,** or a health care provider, who has filed a grievance on behalf of a member, files a grievance with the carrier, and if the carrier does not have sufficient information to complete its internal grievance process, the carrier shall:

(1) notify the member**, THE MEMBER'S REPRESENTATIVE,** or **THE** health care provider that it cannot proceed with reviewing the grievance unless additional information is provided; and

(2) assist the member**, THE MEMBER'S REPRESENTATIVE,** or **THE** health care provider in gathering the necessary information without further delay.

(h) A carrier may extend the 30–day or 45–day period required for making a final grievance decision under subsection (b)(2)(ii) of this section with the written consent of the member**, THE MEMBER'S REPRESENTATIVE,** or the health care provider who filed the grievance on behalf of the member.

(i) (1) For nonemergency cases, when a carrier renders a grievance decision, the carrier shall:

(i) document the grievance decision in writing after the carrier has provided oral communication of the decision to the member**, THE MEMBER'S REPRESENTATIVE,** or the health care provider acting on behalf of the member; and

(ii) send, within 5 working days after the grievance decision has been made, a written notice to the member**, THE MEMBER'S REPRESENTATIVE,** and a health care provider acting on behalf of the member that:

1. states in detail in clear, understandable language the specific factual bases for the carrier's decision;

2. references the specific criteria and standards, including interpretive guidelines, on which the grievance decision was based;

3. states the name, business address, and business telephone number of:

A. the medical director or associate medical director, as appropriate, who made the grievance decision if the carrier is a health maintenance organization; or

B. the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization; and

4. includes the following information:

A. that the member or **THE MEMBER'S REPRESENTATIVE** has a right to file a complaint with the Commissioner within **[**30 working days**] 4 MONTHS** after receipt of a carrier's grievance decision; ~~and~~

B. the Commissioner's address, telephone number, and facsimile number**;**

C. A STATEMENT THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO ASSIST THE MEMBER OR THE MEMBER'S REPRESENTATIVE IN FILING A COMPLAINT WITH THE COMMISSIONER; AND

D. THE ADDRESS, TELEPHONE NUMBER, FACSIMILE NUMBER, AND ELECTRONIC MAIL ADDRESS OF THE HEALTH ADVOCACY UNIT.

(2) A carrier may not use solely in a notice sent under paragraph (1) of this subsection generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary" to satisfy the requirements of this subsection.

(j) (1) For an emergency case under subsection (b)(2)(i) of this section, within 1 day after a decision has been orally communicated to the member**, THE MEMBER'S REPRESENTATIVE,** or **THE** health care provider, the carrier shall send notice in writing of any adverse decision or grievance decision to:

(i) the member **AND THE MEMBER'S REPRESENTATIVE, IF ANY**; and

(ii) if the grievance was filed on behalf of the member under subsection (b)(2)(iii) of this section, the health care provider.

(2) A notice required to be sent under paragraph (1) of this subsection shall include the following:

(i) for an adverse decision, the information required under subsection (f) of this section; and

(ii) for a grievance decision, the information required under subsection (i) of this section.

(k) **(1)** Each carrier shall include the information required by subsection (f)(2)(iii), (iv), and (v) of this section in the policy, plan, certificate, enrollment materials, or other evidence of coverage that the carrier provides to a member at the time of the member's initial coverage or renewal of coverage.

(2) EACH CARRIER SHALL INCLUDE AS PART OF THE INFORMATION REQUIRED BY PARAGRAPH (1) OF THIS SUBSECTION A STATEMENT INDICATING THAT, WHEN FILING A COMPLAINT WITH THE COMMISSIONER, THE MEMBER OR THE MEMBER'S REPRESENTATIVE WILL BE REQUIRED TO AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS OF THE MEMBER THAT MAY BE REQUIRED TO BE REVIEWED FOR THE PURPOSE OF REACHING A DECISION ON THE COMPLAINT.

(l) (1) Nothing in this subtitle prohibits a carrier from delegating its internal grievance process to a private review agent that has a certificate issued under Subtitle 10B of this title and is acting on behalf of the carrier.

(2) If a carrier delegates its internal grievance process to a private review agent, the carrier shall be:

(i) bound by the grievance decision made by the private review agent acting on behalf of the carrier; and

(ii) responsible for a violation of any provision of this subtitle regardless of the delegation made by the carrier under paragraph (1) of this subsection.

15–10A–03.

(a) (1) Within **[**30 working days**]** **4 MONTHS** after the date of receipt of **AN ADVERSE DECISION OR** a grievance decision, a member**, A MEMBER'S REPRESENTATIVE,** or a health care provider, who filed the grievance on behalf of the member under § 15–10A–02(b)(2)(iii) of this subtitle, may file a complaint with the Commissioner **[**for review of the grievance decision**]**.

(2) Whenever the Commissioner receives a complaint under this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(3) Except for an emergency case under subsection (b)(1)(ii) of this section, the carrier that is the subject of a complaint filed under paragraph (1) of this subsection shall provide to the Commissioner any information requested by the Commissioner no later than 7 working days from the date the carrier receives the request for information.

(b) (1) In developing procedures to be used in reviewing and deciding complaints, the Commissioner shall:

(i) allow a health care provider to file a complaint on behalf of a member; and

(ii) establish an expedited procedure for use in an emergency case for the purpose of making a final decision on a complaint within 24 hours after the complaint is filed with the Commissioner.

(2) For purposes of using the expedited procedure for an emergency case under paragraph (1)(ii) of this subsection, the Commissioner shall define by regulation the standards required for a grievance to be considered an emergency case.

(c) (1) Except as provided in paragraph (2) of this subsection and except for an emergency case under subsection (b)(1)(ii) of this section, the Commissioner shall make a final decision on a complaint:

(i) within **[**30 working**]** **45** days after a complaint regarding a pending health care service is filed; and

(ii) within 45 **[**working**]** days after a complaint is filed regarding a retrospective denial of services already provided.

(2) The Commissioner may extend the period within which a final decision is to be made under paragraph (1) of this subsection for up to an additional 30 working days if:

(i) the Commissioner has not yet received information requested by the Commissioner; and

(ii) the information requested is necessary for the Commissioner to render a final decision on the complaint.

(d) ~~In cases considered appropriate by the Commissioner, the Commissioner may~~ **THE COMMISSIONER SHALL** seek advice from an independent review organization or medical expert, as provided in § 15–10A–05 of this subtitle, for complaints filed with the Commissioner under this subtitle that involve a question of whether a health care service provided or to be provided to a member is medically necessary.

(e) (1) A carrier shall have the burden of persuasion that its adverse decision or grievance decision, as applicable, is correct~~[~~**:**

(i)~~]~~ during the review of a complaint by the Commissioner or a designee of the Commissioner~~[~~**;** and

(ii) in any hearing held in accordance with § 2–210 of this article~~]~~.

(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.

(3) As required under § 15–10A–02(i) of this subtitle, the carrier's adverse decision or grievance decision shall state in detail in clear, understandable language the factual bases for the decision and reference the specific criteria and standards, including interpretive guidelines on which the decision was based.

(4) (i) Except as provided in subparagraph (ii) of this paragraph, in responding to a complaint, a carrier may not rely on any basis not stated in its adverse decision or grievance decision.

(ii) The Commissioner may allow a carrier, a member, **A MEMBER'S REPRESENTATIVE,** or a health care provider filing a complaint on behalf of a member to provide additional information as may be relevant for the Commissioner to make a final decision on the complaint.

(III) THE COMMISSIONER SHALL ALLOW THE MEMBER, THE MEMBER'S REPRESENTATIVE, OR THE HEALTH CARE PROVIDER FILING A COMPLAINT ON BEHALF OF THE MEMBER AT LEAST 5 WORKING DAYS TO PROVIDE THE ADDITIONAL INFORMATION DESCRIBED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH.

[(iii)**] (IV)** The Commissioner's use of additional information may not delay the Commissioner's decision on the complaint by more than 5 working days.

(f) The Commissioner may request the member that filed the complaint or a legally authorized designee of the member to sign a consent form authorizing the release of the member's medical records to the Commissioner or the Commissioner's designee that are needed in order for the Commissioner to make a final decision on the complaint.

15–10A–04.

(a) The Commissioner shall:

(1) notwithstanding the provisions of § 15–10A–03(c)(1)(ii) of this subtitle, for the purpose of making final decisions on complaints, prioritize complaints regarding pending health care services over complaints regarding health care services already delivered;

(2) make and issue in writing a final decision on all complaints filed with the Commissioner under this subtitle that are within the Commissioner's jurisdiction; and

(3) provide notice in writing to all parties to a complaint **[**of the opportunity and time period for requesting a hearing to be held in accordance with § 2–210 of this article**]** ~~**THAT THE FINAL DECISION:**~~

~~**(I) IS NOT SUBJECT TO A REQUEST FOR A HEARING UNDER THIS SUBTITLE; AND**~~

~~(II) IS SUBJECT TO A RIGHT TO FILE A PETITION FOR JUDICIAL REVIEW UNDER § 2–215 OF THIS ARTICLE~~ **OF THE AVAILABLE REMEDY TO THE PARTY DESCRIBED UNDER SUBSECTION (E) OF THIS SECTION AND THE TIME PERIOD FOR REQUESTING THE REMEDY**.

(E) (1) A FINAL DECISION OF THE COMMISSIONER MADE ON A COMPLAINT UNDER THIS SUBTITLE:

(I) IS NOT SUBJECT TO A REQUEST FOR A HEARING UNDER THIS SUBTITLE FOR A CARRIER; AND

(II) IS SUBJECT TO A RIGHT TO FILE A PETITION FOR JUDICIAL REVIEW UNDER § 2–215 OF THIS ARTICLE FOR A CARRIER OR A MEMBER.

(2) UNLESS PROHIBITED UNDER FEDERAL LAW, A MEMBER MAY REQUEST A HEARING TO BE HELD IN ACCORDANCE WITH § 2–210 OF THIS ARTICLE OF A FINAL DECISION OF THE COMMISSIONER MADE ON A COMPLAINT UNDER THIS SUBTITLE.

15–10A–05.

(a) For **[**complaints**]** **A COMPLAINT** filed with the Commissioner under this subtitle that **[**involve**]** **INVOLVES** a question of whether the health care service provided or to be provided to a member is medically necessary, the Commissioner**:**

(1) SHALL SELECT AN INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT TO ADVISE ON THE COMPLAINT; AND

(2) may **[**select and**]** accept and base the final decision on **[**a**]** **THE** complaint on the professional judgment of an independent review organization or medical expert.

(b) To ensure access to advice when needed, the Commissioner, in consultation with the Secretary of Health and Mental Hygiene and carriers, shall compile a list of independent review organizations and medical experts.

(c) Any expert reviewer assigned by an independent review organization or medical expert shall be a physician or other appropriate health care provider who meets the following minimum requirements:

(1) be an expert in the treatment of the member's medical condition, and knowledgeable about the recommended health care service or treatment through actual clinical experience;

(2) hold:

(i) a nonrestricted license in a state of the United States; and

(ii) in addition, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of review; and

(3) have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that the Commissioner, in accordance with regulations adopted by the Commissioner, considers relevant in meeting the requirements of this subsection.

(d) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a health benefit plan, or a trade association of health benefit plans, or a trade association of health care providers.

(e) In addition to subsection (d) of this section, to be included on the list compiled under subsection (b) of this section, an independent review organization shall submit to the Commissioner the following information:

(1) if the independent review organization is a publicly held organization, the names of all stockholders and owners of more than 5% of any stock or options of the independent review organization;

(2) the names of all holders of bonds or notes in excess of $100,000, if any;

(3) the names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business; **[**and**]**

(4) the names of all directors, officers, and executives of the independent review organization as well as a statement regarding any relationships the directors, officers, and executives may have with any carrier or health care provider group**; AND**

(5) EVIDENCE, IN THE FORM REQUIRED BY THE COMMISSIONER, THAT THE INDEPENDENT REVIEW ORGANIZATION IS ACCREDITED BY A NATIONALLY RECOGNIZED PRIVATE ACCREDITING ORGANIZATION.

(f) An expert reviewer assigned by an independent review organization or the independent review organization or medical expert selected by the Commissioner

under this section may not have a material professional, familial, or financial conflict of interest with any of the following:

(1) the carrier that is the subject of the complaint;

(2) any officer, director, or management employee of the carrier that is the subject of the complaint;

(3) the health care provider, the health care provider's medical group, or the independent practice association that rendered or is proposing to render the health care service that is under review;

(4) the health care facility at which the health care service was provided or will be provided; or

(5) the developer or manufacturer of the principal drug, device, procedure, or other therapy that is being proposed for the member.

(g) For any independent review organization selected by the Commissioner under subsection (a) of this section, the independent review organization shall have a quality assurance mechanism in place that ensures:

(1) the timeliness and quality of the reviews;

(2) the qualifications and independence of the expert reviewers; and

(3) the confidentiality of medical records and review materials.

(h) (1) The carrier that is the subject of the complaint shall be responsible for paying the reasonable expenses of the independent review organization or medical expert selected by the Commissioner in accordance with subsection (a) of this section.

(2) The independent review organization or medical expert shall:

(i) present to the carrier for payment a detailed account of the expenses incurred by the independent review organization or medical expert; and

(ii) provide a copy of the detailed account of expenses to the Commissioner.

(3) The carrier that is the subject of the complaint may not pay and an independent review organization or medical expert may not accept any compensation in addition to the payment for reasonable expenses under paragraph (1) of this subsection.

15–10A–10.

A CARRIER SHALL PROVIDE THE NOTICES REQUIRED TO BE PROVIDED TO MEMBERS UNDER THIS SUBTITLE IN A CULTURALLY AND LINGUISTICALLY APPROPRIATE MANNER AS DESCRIBED IN THE AFFORDABLE CARE ACT.

15–10D–01.

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

(b) "Appeal" means a protest filed by a member**, A MEMBER'S REPRESENTATIVE,** or a health care provider with a carrier under its internal appeal process regarding a coverage decision concerning a member.

(c) "Appeal decision" means a final determination by a carrier that arises from an appeal filed with the carrier under its appeal process regarding a coverage decision concerning a member.

(d) "Carrier" means a person that offers a health benefit plan and is:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) except for a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that offers a health benefit plan subject to regulation by the State.

(e) "Complaint" means a protest filed with the Commissioner involving a coverage decision other than that which is covered by Subtitle 10A of this title.

(f) (1) "Coverage decision" means**:**

(I) an initial determination by a carrier or a representative of the carrier that results in noncoverage of a health care service**;**

(II) A DETERMINATION BY A CARRIER THAT AN INDIVIDUAL IS NOT ELIGIBLE FOR COVERAGE UNDER THE CARRIER'S HEALTH BENEFIT PLAN; OR

(III) ANY DETERMINATION BY A CARRIER THAT RESULTS IN THE RESCISSION OF AN INDIVIDUAL'S COVERAGE UNDER A HEALTH BENEFIT PLAN.

(2) "Coverage decision" includes nonpayment of all or any part of a claim.

(3) "Coverage decision" does not include:

(i) an adverse decision as defined in § 15–10A–01(b) of this title; or

(ii) a pharmacy inquiry.

(g) "Designee of the Commissioner" means any person to whom the Commissioner has delegated the authority to review and decide complaints filed under this subtitle, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

(h) (1) "Health benefit plan" means:

(i) a hospital or medical policy or contract, including a policy or contract issued under a multiple employer trust or association;

(ii) a hospital or medical policy or contract issued by a nonprofit health service plan;

(iii) a health maintenance organization contract; or

(iv) a dental plan organization contract.

(2) "Health benefit plan" does not include one or more, or any combination of the following:

(i) long–term care insurance;

(ii) disability insurance;

(iii) accidental travel and accidental death and dismemberment insurance;

(iv) credit health insurance;

(v) a health benefit plan issued by a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article;

(vi) disease–specific insurance; or

(vii) fixed indemnity insurance.

(i) "Health care provider" means:

(1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the member; or

(2) a hospital, as defined in § 19–301 of the Health – General Article.

(j) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

(1) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(k) (1) "Member" means a person entitled to health care services under a policy, plan, or contract issued or delivered in the State by a carrier.

(2) "Member" includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) "Member" does not include a Medicaid recipient.

(L) "MEMBER'S REPRESENTATIVE" MEANS AN INDIVIDUAL WHO HAS BEEN AUTHORIZED BY THE MEMBER TO FILE AN APPEAL OR A COMPLAINT ON BEHALF OF THE MEMBER.

[(l)**] (M)** "Pharmacy benefits manager" has the meaning stated in § 15–1601 of this title.

[(m)**] (N)** "Pharmacy inquiry" means an inquiry submitted by a pharmacist or pharmacy on behalf of a member to a carrier or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under a health benefit plan.

15–10D–02.

(a) (1) Each carrier shall establish an internal appeal process for use by its members**, ITS MEMBERS' REPRESENTATIVES,** and health care providers to dispute coverage decisions made by the carrier.

(2) The carrier may use the internal grievance process established under Subtitle 10A of this title to comply with the requirement of paragraph (1) of this subsection.

(b) **[**An internal appeal process established by a**]** **A** carrier under this section shall **[**provide that a carrier**]** render a final decision in writing to a member, **A MEMBER'S REPRESENTATIVE,** and a health care provider acting on behalf of the member**[**,**]** within 60 working days after the date on which the appeal is filed.

(c) Except as provided in subsection (d) of this section, the carrier's internal appeal process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) A member**, A MEMBER'S REPRESENTATIVE,** or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing an appeal with a carrier only if the coverage decision involves an urgent medical condition, as defined by regulation adopted by the Commissioner, for which care has not been rendered.

(e) (1) Within 30 calendar days after a coverage decision has been made, a carrier shall send a written notice of the coverage decision to the member **AND THE MEMBER'S REPRESENTATIVE, IF ANY,** and, in the case of a health maintenance organization, the treating health care provider.

(2) Notice of the coverage decision required to be sent under paragraph (1) of this subsection shall:

(i) state in detail in clear, understandable language, the specific factual bases for the carrier's decision; and

(ii) include the following information:

1. that the member, **THE MEMBER'S REPRESENTATIVE,** or a health care provider acting on behalf of the member**[**,**]** has a right to file an appeal with the carrier;

2. that the member, **THE MEMBER'S REPRESENTATIVE,** or a health care provider acting on behalf of the member**[**,**]** may file a complaint with the Commissioner without first filing an appeal, if the coverage decision involves an urgent medical condition for which care has not been rendered;

3. the Commissioner's address, telephone number, and facsimile number;

4. that the Health Advocacy Unit is available to assist the member **OR THE MEMBER'S REPRESENTATIVE** in both mediating and filing an appeal under the carrier's internal appeal process; and

5. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(f) (1) Within 30 calendar days after the appeal decision has been made, each carrier shall send to the member, **THE MEMBER'S REPRESENTATIVE,** and the health care provider acting on behalf of the member**[**,**]** a written notice of the appeal decision.

(2) Notice of the appeal decision required to be sent under paragraph (1) of this subsection shall:

(i) state in detail in clear, understandable language the specific factual bases for the carrier's decision; and

(ii) include the following information:

1. that the member, **THE MEMBER'S REPRESENTATIVE,** or a health care provider acting on behalf of the member**[**,**]** has a right to file a complaint with the Commissioner within **[**60 working days**]** **4 MONTHS** after receipt of a carrier's appeal decision; ~~and~~

2. the Commissioner's address, telephone number, and facsimile number**;**

3. A STATEMENT THAT THE HEALTH ADVOCACY UNIT IS AVAILABLE TO ASSIST THE MEMBER IN FILING A COMPLAINT WITH THE COMMISSIONER; AND

4. THE ADDRESS, TELEPHONE NUMBER, FACSIMILE NUMBER, AND ELECTRONIC MAIL ADDRESS OF THE HEALTH ADVOCACY UNIT.

(g) The Commissioner may request the member that filed the complaint or a legally authorized designee of the member to sign a consent form authorizing the release of the member's medical records to the Commissioner or the Commissioner's designee that are needed in order for the Commissioner to make a final decision on the complaint.

(h) (1) A carrier shall have the burden of persuasion that its coverage decision or appeal decision, as applicable, is correct:

(i) during the review of a complaint by the Commissioner or a designee of the Commissioner; and

(ii) in any hearing held in accordance with Title 10, Subtitle 2 of the State Government Article to contest a final decision of the Commissioner made and issued under this subtitle.

(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.

(i) The Commissioner shall:

(1) make and issue in writing a final decision on all complaints filed with the Commissioner under this subtitle that are within the Commissioner's jurisdiction; and

(2) provide notice in writing to all parties to a complaint of the opportunity and time period for requesting a hearing to be held in accordance with Title 10, Subtitle 2 of the State Government Article to contest a final decision of the Commissioner made and issued under this subtitle.

15–10D–05.

A CARRIER SHALL PROVIDE THE NOTICES REQUIRED TO BE PROVIDED TO MEMBERS UNDER THIS SUBTITLE IN A CULTURALLY AND LINGUISTICALLY APPROPRIATE MANNER AS DESCRIBED IN THE AFFORDABLE CARE ACT.

15–1206.

(c) (1) Subject to the approval of the Commissioner and as provided under this subsection and § 15–1209(d) of this subtitle, a carrier may impose reasonable minimum participation requirements.

(2) A carrier may not impose a requirement for minimum participation by the eligible employees of a small employer that is greater than 75%.

(3) In applying a minimum participation requirement to determine whether the applicable percentage of participation is met, a carrier may not consider as eligible employees**:**

(I) those who have group spousal coverage under a public or private plan of health insurance or another employer's health benefit arrangement, including Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or exceeding the benefits provided under the Standard Plan**; OR**

(II) EMPLOYEES WHO ARE UNDER THE AGE OF 26 YEARS WHO ARE COVERED UNDER THEIR PARENT'S HEALTH BENEFIT PLAN.

(4) A carrier may not impose a minimum participation requirement for a small employer group if any member of the group participates in a medical savings account.

15–1207.

(a) In accordance with Title 19, Subtitle 1 of the Health – General Article, the Commission shall adopt regulations that specify:

(1) the Comprehensive Standard Health Benefit Plan to apply under this subtitle; and

(2) the requirements for a wellness benefit offered by a carrier to apply under this subtitle.

(b) (1) Subject to paragraph (2) of this subsection, the Commission shall exclude or limit benefits or adjust cost–sharing arrangements in the Standard Plan if the average rate for the Standard Plan exceeds 10% of the average annual wage in the State.

(2) The Commission annually shall determine the average rate for the Standard Plan by using the average rate submitted by each carrier that offers the Standard Plan.

(c) In establishing benefits, the Commission shall judge preventive services, medical treatments, procedures, and related health services based on:

(1) their effectiveness in improving the health status of individuals;

(2) their impact on maintaining and improving health and on reducing the unnecessary consumption of health care services; and

(3) their impact on the affordability of health care coverage.

(d) The Commission may exclude:

(1) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health – General

Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(2) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

(E) THE COMMISSION SHALL INCLUDE MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS REQUIRED UNDER § 15–802 OF THIS TITLE AND § 19–703.1 OF THE HEALTH – GENERAL ARTICLE FOR EMPLOYERS THAT MEET THE LARGE EMPLOYER DEFINITION UNDER § 15–802 OF THIS TITLE AND § 19–703.1 OF THE HEALTH – GENERAL ARTICLE.

[(e)**] (F)** The Commission shall specify the deductibles and cost–sharing associated with the benefits in the Standard Plan.

[(f)**] (G)** In establishing cost–sharing as part of the Standard Plan, the Commission shall:

(1) include cost–sharing and other incentives to help prevent consumers from seeking unnecessary services;

(2) balance the effect of cost–sharing in reducing premiums and in affecting utilization of appropriate services; and

(3) limit the total cost–sharing that may be incurred by an individual in a year.

Article – Health – General

19–703.1.

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

(2) "Alcohol abuse" has the meaning stated in § 8–101 of this article.

(3) "Drug abuse" has the meaning stated in § 8–101 of this article.

(4) "Health benefit plan" has the meaning stated in § 15–1401 of the Insurance Article.

(5) "Large employer" means an employer that has more than 50 employees and is not a small employer.

(6) "Managed care system" means a method that a carrier uses to review and preauthorize a treatment plan that a health care practitioner develops for

a covered person using a variety of cost containment methods to control utilization, quality, and claims.

(7) "Partial hospitalization" means the provision of medically directed intensive or intermediate short–term treatment for mental illness, emotional disorders, drug abuse or alcohol abuse for a period of less than 24 hours but more than 4 hours in a day for a member or subscriber in a licensed or certified facility or program.

(8) "Small employer" **[**has the meaning stated in § 15–1201 of the Insurance Article**]** **MEANS AN EMPLOYER THAT:**

(I) EMPLOYED AN AVERAGE OF AT LEAST TWO, BUT NOT MORE THAN 50 EMPLOYEES ON BUSINESS DAYS DURING THE PRECEDING CALENDAR YEAR; AND

(II) EMPLOYS AT LEAST TWO EMPLOYEES ON THE FIRST DAY OF THE PLAN YEAR.

19–706.

(KKKK) THE PROVISIONS OF § 15–137.1 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

19–732.

(a) **[**A**]** **EXCEPT AS OTHERWISE PROVIDED IN TITLE 15, SUBTITLE 10A OF THE INSURANCE ARTICLE, A** party aggrieved by a final action of the Commissioner under this subtitle has the right to a hearing and the right to appeal from the action of the Commissioner under §§ 2–210 through 2–215 of the Insurance Article.

SECTION 2. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall apply, for group health benefit plans, to plan years that begin on or after July 1, 2011, and for individual health benefit plans, for policy years that begin on or after July 1, 2011.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2011.

Approved by the Governor, April 12, 2011.