

SENATE BILL 887

C3

6lr3427
CF 6lr2815

By: **Senator Middleton**

Introduced and read first time: February 5, 2016

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Consumer Health Claim Filing Fairness Act**

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

13 BY repealing and reenacting, with amendments,
14 Article – Insurance
15 Section 12–102 and 15–213
16 Annotated Code of Maryland
17 (2011 Replacement Volume and 2015 Supplement)

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

20 **Article – Insurance**

21 12–102.

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

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

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



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

3 (ii) approves the policy.

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

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

8 (II) "CARRIER" MEANS:

9 1. AN INSURER AUTHORIZED TO SELL HEALTH
10 INSURANCE;

11 2. A NONPROFIT HEALTH SERVICE PLAN;

12 3. A HEALTH MAINTENANCE ORGANIZATION;

13 4. A DENTAL PLAN ORGANIZATION; OR

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

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

19 (IV) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN §
20 15-140 OF THIS ARTICLE.

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

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

25 (II) PROVIDE THAT:

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

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

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

6 **1. THE DELAY WAS NOT UNREASONABLE; AND**

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

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

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

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

18 15–213.

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

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

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

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