HB0170/956680/1

BY: Health and Government Operations Committee

AMENDMENTS TO HOUSE BILL 170
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 5, after the semicolon, insert "requiring the Commissioner to file certain documents in a court in which a certain appeal is pending;"; in the same line, after the second "certain" insert "health insurance coverage issued or delivered by certain"; in line 10, after "requiring" insert "certain health insurance coverage issued or delivered by"; in line 15, after "timeframes," insert "notices,"; and in line 16, after the semicolon, insert "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;".

On page 2, in line 12, after "2-215(a)" insert ", (b), (d), and (g)"; in line 17, after "15-10A-01(m)," insert "15-10A-04(e),"; and in line 23, after "15-10A-04(a)" insert ", 15-10A-05".

AMENDMENT NO. 2

On page 3, in line 24, strike "**TITLE 15, SUBTITLE 10A**" and substitute "**§ 15-10A-04**"; and after line 25, insert:

"(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**

(Over)

(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.".

AMENDMENT NO. 3

On pages 3 and 4, strike beginning with "**FEDERAL**" in line 28 on page 3 down through "**STATE**" in line 7 on page 4 and substitute "**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**".

(Over)

On page 4, in line 22, after "**(B)**" insert "**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)".

AMENDMENT NO. 4

On page 5, strike in their entirety lines 29 through 31, inclusive, and substitute:

"**(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**";

and after line 34, insert:

"**(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).**".

On page 6, in line 1, strike "**(II)**" and substitute "**(III)**"; and in line 3, after "**RATIO**" insert "**REPORTED IN THE MANNER REQUIRED UNDER 45 C.F.R. § 158**".

AMENDMENT NO. 5

On page 10, in line 25, after "**COMMISSIONER**" insert "**AND THE HEALTH ADVOCACY UNIT**".

On page 11, in line 27, after "member" insert "**OR THE MEMBER'S REPRESENTATIVE**".

On page 12, in line 33, strike "and".

On page 13, in line 2, after "number" insert "**;**

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".

AMENDMENT NO. 6

On page 15, strike beginning with "In" in line 10 down through "may" in line 11 and substitute "**THE COMMISSIONER SHALL**"; and in lines 16, 17, 18, and 20, in each instance, strike the bracket.

AMENDMENT NO. 7

On page 16, strike beginning with "**THAT**" in line 25 down through "**ARTICLE**" in line 29 and substitute "**OF THE AVAILABLE REMEDY TO THE PARTY DESCRIBED UNDER SUBSECTION (E) OF THIS SECTION AND THE TIME PERIOD FOR REQUESTING THE REMEDY**".

AMENDMENT NO. 8

On page 16, after line 29, insert:

"**(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:

(Over)

(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.

(Over)

(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.".

AMENDMENT NO. 9

On page 21, in line 11, strike "and"; and in line 13, after "number" insert "**;**

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".