Chapter 11

(Senate Bill 56)

AN ACT concerning

Health Insurance – Evaluation of Quality of Care and Performance of Health Benefit Plans

FOR the purpose of altering certain requirements for and purposes of a certain system that the Maryland Health Care Commission is required to establish and implement; requiring the system to comparatively evaluate the quality of care and performance of certain categories of health benefit plans; establishing that a purpose of the system is to assist certain health insurance carriers to improve care; requiring the system to solicit performance information from enrollees of certain health benefit plans; altering the entities the recommendations of which the Commission must consider before implementing the system; altering the contents of a certain annual evaluation summary; defining certain terms; making certain conforming changes; and generally relating to evaluations of quality of care and performance of health benefit plans.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–132 and 19–134(c)
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 – Health – General

19–132.

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

(b) "Ambulatory surgical facility" has the meaning stated in § 19–3B–01 of this title.

(C) "CARRIER" MEANS:

(1) ~~A HEALTH~~ AN INSURER OR NONPROFIT HEALTH SERVICE PLAN THAT HOLDS A CERTIFICATE OF AUTHORITY AND PROVIDES HEALTH

INSURANCE POLICIES OR CONTRACTS IN THE STATE IN ACCORDANCE WITH ~~THIS ARTICLE OR~~ THE INSURANCE ARTICLE; OR

(2) A HEALTH MAINTENANCE ORGANIZATION THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE STATE.

[(c)**] (D)** "Comprehensive standard health benefit plan" means the comprehensive standard health benefit plan adopted in accordance with § 15–1207 of the Insurance Article.

(E) (1) "HEALTH BENEFIT PLAN" MEANS A HOSPITAL OR MEDICAL POLICY, CONTRACT, OR CERTIFICATE ISSUED BY A CARRIER.

(2) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

(I) COVERAGE FOR ACCIDENT OR DISABILITY INCOME INSURANCE;

(II) COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

(III) LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

(IV) WORKERS' COMPENSATION OR SIMILAR INSURANCE;

(V) AUTOMOBILE OR PROPERTY MEDICAL PAYMENT INSURANCE;

(VI) CREDIT–ONLY INSURANCE;

(VII) COVERAGE FOR ON–SITE MEDICAL CLINICS;

(VIII) DENTAL OR VISION INSURANCE;

(IX) LONG–TERM CARE INSURANCE OR BENEFITS FOR NURSING HOME CARE, HOME HEALTH CARE, COMMUNITY–BASED CARE, OR ANY COMBINATION OF THESE;

(X) COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS;

(XI) HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE; OR

(XII) THE FOLLOWING BENEFITS IF OFFERED AS A SEPARATE INSURANCE POLICY:

1. MEDICARE SUPPLEMENTAL HEALTH INSURANCE, AS DEFINED IN § 1882(G)(1) OF THE SOCIAL SECURITY ACT;

2. COVERAGE SUPPLEMENTAL TO THE COVERAGE PROVIDED UNDER CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE; OR

3. SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO COVERAGE UNDER AN EMPLOYER SPONSORED PLAN.

[(d)**] (F)** "Health care practitioner" means any individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

[(e)**] (G)** (1) "Health care provider" means:

(i) A person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care in the ordinary course of business or practice of a profession or in an approved education or training program; or

(ii) A facility where health care is provided to patients or recipients, including:

1. A facility, as defined in § 10–101(e) of this article;

2. A hospital, as defined in § 19–301 of this title;

3. A related institution, as defined in § 19–301 of this title;

4. A health maintenance organization, as defined in § 19–701(g) of this title;

5. An outpatient clinic; and

6. A medical laboratory.

(2) "Health care provider" includes the agents and employees of a facility who are licensed or otherwise authorized to provide health care, the officers and directors of a facility, and the agents and employees of a health care provider who are licensed or otherwise authorized to provide health care.

[(f)**] (H)** "Health care service" means any health or medical care procedure or service rendered by a health care practitioner that:

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

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

[(g)**] (I)** "Hospital" has the meaning stated in § 19–301 of this title.

[(h)**] (J)** (1) "Mandated health insurance service" means a legislative proposal or statute that would require a particular health care service to be provided or offered in a health benefit plan, by a carrier or other organization authorized to provide health benefit plans in the State.

(2) "Mandated health insurance service", as applicable to all carriers, does not include services enumerated to describe a health maintenance organization under § 19–701(g)(2) of this title.

[(i)**] (K)** "Nursing facility" has the meaning stated in § 19–1401 of this title.

[(j)**] (L)** (1) "Office facility" means the office of one or more health care practitioners in which health care services are provided to individuals.

(2) "Office facility" includes a facility that provides:

(i) Ambulatory surgery;

(ii) Radiological or diagnostic imagery; or

(iii) Laboratory services.

(3) "Office facility" does not include any office, facility, or service operated by a hospital and regulated under Part II of this subtitle.

[(k)**] (M)** "Payor" means:

(1) A health insurer or nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in the State in accordance with this article or the Insurance Article;

(2) A health maintenance organization that holds a certificate of authority in the State; or

(3) For the purposes of this Part III of this subtitle only, a person that is registered as an administrator under Title 8, Subtitle 3 of the Insurance Article.

19–134.

(c) (1) The Commission shall:

(i) Establish and implement a system to comparatively evaluate the quality of care **[**outcomes**]** and performance **[**measurements**]** of **[**health maintenance organization**]** ~~**HEALTH benefit plans**~~ **CATEGORIES OF HEALTH BENEFIT PLANS AS DETERMINED BY THE COMMISSION** **[**and services**]** on an objective basis; and

(ii) Annually publish the summary findings of the evaluation.

(2) The purpose of **[**a comparable performance measurement**]** **THE EVALUATION** system established under this subsection is to assist **[**health maintenance organization**]** **CARRIERS** **[**benefit plans**]** to improve **[**the quality of**]** care **[**provided**]** by establishing a common set of **QUALITY AND** performance measurements and disseminating the findings **[**of the performance measurements**]** to **[**health maintenance organizations**]** **CARRIERS** and **OTHER** interested parties.

(3) The system, where appropriate, shall:

(i) Solicit performance information from enrollees of **[**health maintenance organizations**]** **HEALTH BENEFIT PLANS**; and

(ii) On or before October 1, 2007, to the extent feasible, incorporate racial and ethnic variations.

(4) (i) The Commission shall adopt regulations to establish the system of evaluation provided under this subsection.

(ii) Before adopting regulations to implement an evaluation system under this subsection, the Commission shall consider **[**any**]** recommendations of **[**the quality of care subcommittee of the Group Health Association of America and the National Committee for Quality Assurance**]** **NATIONALLY RECOGNIZED ORGANIZATIONS THAT ARE INVOLVED IN QUALITY OF CARE AND PERFORMANCE MEASUREMENT**.

(5) The Commission may contract with a private, nonprofit entity to implement the system required under this subsection provided that the entity is not an insurer.

(6) The annual evaluation summary required under paragraph (1) of this subsection shall**[**:

(i) Include a summary of the Drug Formulary Accreditation Standards of the National Committee for Quality Assurance (NCQA);

(ii) Indicate whether the formulary development process of each health maintenance organization evaluated complies with the National Committee for Quality Assurance (NCQA) accreditation standards; and

(iii) Include**]** **INCLUDE** to the extent feasible information on racial and ethnic variations.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2011.

Approved by the Governor, April 12, 2011.