SB0096/537177/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL 96
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 5, after "permit;" insert "providing that certain provisions of the federal Patient Protection and Affordable Care Act relating to guaranteed availability of coverage apply to certain coverage offered in certain insurance markets;"; in line 10, after "circumstances;" insert "providing a certain exception to the requirement that certain insurance carriers take certain action in relation to a certain claim within a certain number of days; authorizing certain insurance carriers to suspend review of a claim for reimbursement for certain services under certain circumstances;"; in line 23, strike "repealing" and substitute "altering"; and in line 26, after "coverage;" insert "altering the date by which carriers that sell health benefit plans to individuals in the State are required to establish a certain enrollment period; specifying the dates on which certain enrollment periods begin and end; providing for certain effective dates of coverage in the individual insurance market;".

On page 2, in line 8, after "2-112(a)," insert "15-137.1(a), 15-1005, 15-1009,".

AMENDMENT NO. 2

On page 5, after line 18, insert:

"15-137.1.

(a) Notwithstanding any other provisions of law, the following provisions of Title I, Subtitles A, C, and D of the 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,

(Over)

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;

(13) disclosure of information;

(14) annual limitations on cost sharing;

(15) child–only plan offerings in the individual market;

(16) minimum benefit requirements for catastrophic plans;

(17) health insurance premium rates;

(18) coverage for individuals participating in approved clinical trials; **[**and**]**

(19) contract requirements for stand–alone dental plans sold on the Maryland Health Benefit Exchange**; AND**

(20) GUARANTEED AVAILABILITY OF COVERAGE.".

AMENDMENT NO. 3

On page 14, in line 4, strike "**REGARDLESS OF ANY**" and substitute "**, PROVIDED THAT THE INDIVIDUAL DOES NOT MEET THE INITIAL STANDARD BECAUSE OF A**".

AMENDMENT NO. 4

On page 15, after line 17, insert:

"15–1005.

(a) In this section, "clean claim" means a claim for reimbursement, as defined in regulations adopted by the Commissioner under § 15–1003 of this subtitle.

(b) To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq., this section applies to an insurer, nonprofit health service plan, or health maintenance organization that acts as a third party administrator.

(c) Except as provided in § 15–1315 of this title **AND SUBSECTION (H) OF THIS SECTION**, within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement under § 15–701(a) of this title or from a hospital or related institution, as those terms are defined in § 19–301 of the Health – General Article, an insurer, nonprofit health service plan, or health maintenance organization shall:

(1) mail or otherwise transmit payment for the claim in accordance with this section; or

(2) send a notice of receipt and status of the claim that states:

(i) that the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;

(ii) that, in accordance with § 15–1003(d)(1)(ii) of this subtitle, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or

(iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

(d) (1) An insurer, nonprofit health service plan, or health maintenance organization shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service.

(2) If an insurer, nonprofit health service plan, or health maintenance organization wholly or partially denies a claim for reimbursement, the insurer, nonprofit health service plan, or health maintenance organization shall permit a

provider a minimum of 90 working days after the date of denial of the claim to appeal the denial.

(3) If an insurer, nonprofit health service plan, or health maintenance organization erroneously denies a provider's claim for reimbursement submitted within the time period specified in paragraph (1) of this subsection because of a claims processing error, and the provider notifies the insurer, nonprofit health service plan, or health maintenance organization of the potential error within 1 year of the claim denial, the insurer, nonprofit health service plan, or health maintenance organization, on discovery of the error, shall reprocess the provider's claim without the necessity for the provider to resubmit the claim, and without regard to timely submission deadlines.

(e) (1) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(i) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall mail or otherwise transmit payment for any undisputed portion of the claim within 30 days of receipt of the claim, in accordance with this section.

(2) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(ii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall:

(i) mail or otherwise transmit payment for any undisputed portion of the claim in accordance with this section; and

(ii) comply with subsection (c)(1) or (2)(i) of this section within 30 days after receipt of the requested additional information.

(3) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(iii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall comply with

subsection (c)(1) or (2)(i) of this section within 30 days after receipt of the requested additional information.

(f) (1) If an insurer, nonprofit health service plan, or health maintenance organization fails to pay a clean claim for reimbursement or otherwise violates any provision of this section, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest on the amount of the claim that remains unpaid 30 days after receipt of the initial clean claim for reimbursement at the monthly rate of:

(i) 1.5% from the 31st day through the 60th day;

(ii) 2% from the 61st day through the 120th day; and

(iii) 2.5% after the 120th day.

(2) The interest paid under this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest.

(g) An insurer, nonprofit health service plan, or health maintenance organization that violates a provision of this section is subject to:

(1) a fine not exceeding $500 for each violation that is arbitrary and capricious, based on all available information; and

(2) the penalties prescribed under § 4–113(d) of this article for violations committed with a frequency that indicates a general business practice.

(H) (1) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION MAY SUSPEND REVIEW OF A CLAIM FOR REIMBURSEMENT FOR A PREAUTHORIZED OR APPROVED HEALTH CARE

SERVICE IF THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SENDS WRITTEN NOTICE WITHIN 30 DAYS AFTER RECEIPT OF THE CLAIM THAT INFORMS THE PERSON FILING THE CLAIM, THAT:

(I) REVIEW OF THE CLAIM IS SUSPENDED DURING THE SECOND OR THIRD MONTH OF A GRACE PERIOD UNDER 45 C.F.R. § 156.270(D); AND

(II) ON RECEIPT OF THE PAYMENT OF PREMIUM, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION IS REQUIRED TO COMPLY WITH PARAGRAPH (2) OF THIS SUBSECTION.

(2) WITHIN 30 DAYS AFTER RECEIPT OF THE PAYMENT OF PREMIUM, AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION SHALL COMPLY WITH SUBSECTION (C)(1) OR (2) OF THIS SECTION.

15–1009.

(a) In this section, "carrier" means:

(1) an insurer;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) any other person that provides health benefit plans subject to regulation by the State.

(b) If a health care service for a patient has been preauthorized or approved by a carrier or the carrier's private review agent, the carrier may not deny reimbursement to a health care provider for the preauthorized or approved service delivered to that patient unless:

(1) the information submitted to the carrier regarding the service to be delivered to the patient was fraudulent or intentionally misrepresentative;

(2) critical information requested by the carrier regarding the service to be delivered to the patient was omitted such that the carrier's determination would have been different had it known the critical information;

(3) a planned course of treatment for the patient that was approved by the carrier was not substantially followed by the health care provider; or

(4) on the date the preauthorized or approved service was delivered:

(i) the patient was not covered by the carrier;

(ii) the carrier maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and

(iii) according to the verification system, the patient was not covered by the carrier.

(C) NOTWITHSTANDING SUBSECTTION (B) OF THIS SECTION, A CARRIER MAY SUSPEND REVIEW OF A CLAIM FOR REIMBURSEMENT OF A PREAUTHORIZED OR APPROVED HEALTH CARE SERVICE IF:

(1) THE PATIENT IS IN THE SECOND OR THIRD MONTH OF A GRACE PERIOD UNDER 45 C.F.R. § 156.270(D);

(2) THE CARRIER MAINTAINS AN AUTOMATED ELIGIBILITY VERIFICATION SYSTEM THAT WAS AVAILABLE TO THE HEALTH CARE PROVIDER BY TELEPHONE OR VIA THE INTERNET AT THE TIME THE HEALTH CARE SERVICE WAS PROVIDED;

(3) ACCORDING TO THE VERIFICATION SYSTEM, THE PROVIDER IS INFORMED THAT:

(I) THE PATIENT IS IN THE SECOND OR THIRD MONTH OF A GRACE PERIOD AND REVIEW OF A CLAIM FOR REIMBURSEMENT MAY BE SUSPENDED; AND

(II) A CARRIER IS NOT PROHIBITED FROM DENYING A CLAIM FOR REIMBURSEMENT OF A SUSPENDED CLAIM; AND

(4) THE CARRIER COMPLIES WITH THE NOTICE AND CLAIM PAYMENT REQUIREMENTS UNDER § 15-1005 OF THIS SUBTITLE.

[(c)**](D)** A carrier shall pay a claim for a preauthorized or approved covered health care service in accordance with §§ 15–1005 and 15–1008 of this subtitle.".

AMENDMENT NO. 5

On page 20, in line 13, strike "qualified"; and in the same line, after "health" insert "**BENEFIT**".

On page 23, in lines 1 and 3, in each instance, strike the bracket; and strike beginning with "and" in line 2 down through "title" in line 3.

AMENDMENT NO. 6

On page 26, strike in their entirety lines 1 through 4, inclusive, and substitute:

"(b) (1) Beginning **[**October 15, 2014,**]** **NOVEMBER 15, 2014, UNLESS AN ALTERNATIVE DATE IS ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES,** a carrier that sells health benefit plans to individuals in the state shall establish an annual open enrollment period.

(2) THE ANNUAL OPEN ENROLLMENT PERIOD FOR 2014 SHALL BEGIN ON NOVEMBER 15, 2014, AND EXTEND THROUGH JANUARY 15, 2015, UNLESS ALTERNATIVE DATES ARE ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES.

[(2)**](3)** The annual open enrollment period **FOR YEARS BEGINNING ON AND AFTER JANUARY 1, 2015,** shall begin on October 15 and extend through December 7 each year.";

in line 5, strike "(3)" and substitute "**(4)**"; strike in their entirety lines 12 through 14, inclusive, and substitute:

"**[**(4)**](5) IF AN INDIVIDUAL ENROLLS IN A HEALTH BENEFIT PLAN OFFERED BY THE CARRIER DURING THE ANNUAL OPEN ENROLLMENT PERIOD FOR 2014, THE EFFECTIVE DATE OF COVERAGE SHALL BE:**

(I) JANUARY 1, 2015, IF THE APPLICATION IS RECEIVED BY THE CARRIER ON OR BEFORE DECEMBER 15, 2014, UNLESS AN ALTERNATIVE

DATE IS ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND

(II) FEBRUARY 1, 2015, IF THE APPLICATION IS RECEIVED BY THE CARRIER FROM DECEMBER 16, 2014, THROUGH JANUARY 15, 2015, UNLESS AN ALTERNATIVE DATE IS ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(6) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period **FOR YEARS BEGINNING ON AND AFTER JANUARY 1, 2015**, the effective date of coverage shall be January 1 of the following calendar year.".