

Article - Insurance

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§15–123.

- (a) (1) In this section the following words have the meanings indicated.
- (2) “Carrier” means:
- (i) an insurer;
 - (ii) a nonprofit health service plan;
 - (iii) a health maintenance organization;
 - (iv) a dental plan organization;
 - (v) any person or entity acting as a third party administrator; or
 - (vi) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health - General Article, any other person that provides health benefit plans subject to regulation by the State.
- (3) “Contract” means any written agreement between a provider and a carrier for the provider to render health care services to enrollees of the carrier.
- (4) “Diagnostic services” means any medical or surgical service or procedure that allows a provider to identify or diagnose a human disease or disorder.
- (5) “Enrollee” means any person or subscriber entitled to health care benefits from a carrier.
- (6) “Health care services” means a health or medical care procedure or service rendered by a provider that:
- (i) provides testing, diagnosis, or treatment of a human disease or dysfunction; or
 - (ii) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.
- (7) (i) “Provider” means a person or entity licensed, certified, or otherwise authorized under the Health Occupations Article or the Health - General Article to provide health care services.
- (ii) “Provider” includes:
- 1. a health care facility;

2. a pharmacy;
3. a professional services corporation;
4. a partnership;
5. a limited liability company;
6. a professional office; or
7. any other entity licensed or authorized by law to provide or deliver professional health care services through or on behalf of a provider.

(8) “Therapeutic services” means any medical or surgical service or procedure that a provider can use to treat a human disease or disorder.

(b) This section applies to any carrier that provides health care services to enrollees or otherwise makes health care services available to enrollees through contracts with providers.

(c) The section does not:

(1) apply to any cosmetic or medically unnecessary service or procedure that typically would be excluded from coverage by any carrier that issues or delivers contracts or policies of health insurance in the State; or

(2) affect the right of an enrollee to appeal any adverse decision by a carrier through the carrier’s appeal process.

(d) (1) Each carrier shall disclose to providers and enrollees the carrier’s definition of “experimental medical care”.

(2) The carrier shall disclose the definition in:

(i) contracts offered to providers that may render direct health care services to the enrollees of the carrier; and

(ii) marketing materials and enrollment materials of the carrier that are provided to current enrollees and prospective enrollees, as appropriate.

(e) Each carrier shall establish or subscribe or contract to provide a systematic, scientific process to follow for evaluating emerging medical and surgical treatments to ensure that subscribers have access to the latest appropriate treatments.

(f) The process established or subscribed to or contracted for by a carrier under subsection (e) of this section shall include:

(1) a comprehensive review of medical literature and data evaluation; and

(2) input from physicians and other recognized experts:

(i) who are not employees of the carrier; and

(ii) who:

1. are currently treating patients for the disease or condition being evaluated;

2. are board certified in the pertinent specialty or subspecialty area of the disease or condition being evaluated;

3. are generally recognized by their peers to be authoritative resources in the clinical area being evaluated as evidenced by:

A. faculty appointments;

B. authorship of a significant body of peer-reviewed clinical literature in the pertinent specialty or subspecialty area; or

C. a demonstrated history of leadership in local, State, or national professional associations and nonprofit patient and community advocacy organizations that address the disease or condition and the specialty or subspecialty area in question; or

4. have a demonstrated history of substantial experience and practical knowledge in the specialty or subspecialty area in question.

(g) A carrier's decision to provide coverage for an emerging medical or surgical treatment shall result from the consensus of opinion from its own analysis and the knowledge provided to the carrier from the process identified by the carrier in subsection (f) of this section.

(h) Each carrier, in conjunction with the clinical experts identified by the carrier under subsection (f)(2) of this section, shall decide the patient selection criteria for an emerging medical or surgical treatment for which coverage by the carrier is to be provided.

(i) Each carrier shall provide a description of the process identified by the carrier under subsection (f) of this section to enrollees and contracting providers and all other providers on request.

(j) (1) A carrier's coverage decision on an emerging medical or surgical treatment shall be in compliance with § 15-10B-07 of this title, when being appealed by an enrollee.

(2) A carrier may reevaluate annually whether scientific advances warrant a change in the carrier's coverage and payment policy for an emerging

medical or surgical treatment.

(k) (1) Each carrier shall file annually with the Commissioner a summary description of the clinical issues and diagnostic and therapeutic services that were evaluated and the conclusion of the evaluation, including the opinions of the clinical experts.

(2) The Commissioner shall:

(i) make each carrier's filing under paragraph (1) of this subsection available to the public for inspection and review; and

(ii) provide a copy of a carrier's filing under paragraph (1) of this subsection to any person upon request in a timely manner and at a reasonable cost to the person.

(l) After notifying a carrier and providing an opportunity for a hearing, the Commissioner may issue an order under § 4-113(d) of this article for a violation of this section.

(m) (1) The Commissioner may waive the application of subsection (f) of this section for a carrier that has in place a process for evaluating emerging medical and surgical treatments used for the purpose of making coverage decisions, if the Commissioner determines that the carrier's process is substantially equivalent to, or exceeds, the requirements of this section.

(2) A carrier receiving a waiver under paragraph (1) of this subsection shall report any change in its process for evaluating emerging medical and surgical treatments to the Commissioner.

(3) The Commissioner may withdraw a waiver granted under paragraph (1) of this subsection whenever the Commissioner determines that the carrier's process for evaluating emerging medical and surgical treatments is not substantially equivalent to the requirements of this section.

(n) The Commissioner may adopt regulations to carry out this section.

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